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and the

PRINCIPAL SCHOOL MEDICAL
OFFICER

YEAR 1962

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(as at 31.12.62)

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STANDING SUB-COMMITTEES OF THE WEST RIDING HEALTH COMMITTEE

Ambulance Sub-Committee.—All matters relating to the County Ambulance Service. (Section 27, National Health Service Act, 1946.)

Public Health Sub-Committee.—Matters relating to the Pharmacy and Poisons Act, 1933; Housing (Rural Workers) Acts, 1926 and 1942; Housing Acts; Rural Water Supplies and Sewerage Acts, 1944-61; Nurses' Act, 1957; Vaccination and Immunisation (Section 26), Venereal Diseases, Public Health Propaganda (Section 28), under the National Health Service Act, 1946; Food and Drugs Act, 1955; Milk (Special Designation) Regulations, 1960; Shops Act, 1950; and all other powers and duties of the Health Authority not delegated to another Standing Sub-Committee.

Mental Health Sub-Committee.—All matters relating to the duties of the Local Health Authority under the Mental Health Act, 1959, and the care and after-care of persons suffering from mental disorder. (Section 28, National Health Service Act, 1946.)

Welfare Sub-Committee.—Arrangements for the prevention of illness, the care of persons suffering from illness other than mental illness, or the after-care of such persons. (Section 28, National Health Service Act, 1946, and the Public Health (Tuberculosis) Regulations, 1952.)

Arrangements for promoting the welfare of persons who are blind, deaf or dumb and other persons who are substantially and permanently handicapped by illness, injury, or congenital deformity, or such other disabilities as may be prescribed by the Minister of Health, and arrangements with Voluntary Organisations therefor. (Sections 29 and 30, National Assistance Act, 1948.)

Assistance grants to Voluntary Organisations providing meals or recreational facilities for old people. (Section 31, National Assistance Act, 1948.)

Arrangements for the protection of property of persons admitted to hospitals, etc. (Section 48, National Assistance Act, 1948.)

The recovery of charges and expenses where permissible in respect of all services provided by the Health Committee.

The West Riding Distress Fund.

Welfare Accommodation Sub-Committee.—The provision and management of residential accommodation for persons who, by reason of age, infirmity or any other circumstances, are in need of care and attention which is not otherwise available to them. (Sections 21-24, National Assistance Act, 1948.)

Arrangements with Voluntary Organisations and other Local Authorities for the provision of accommodation in property maintained by them. (Section 26, National Assistance Act, 1948.)

The registration of disabled persons' or aged persons' homes. (Sections 37-39, National Assistance Act, 1948.)

Registration of charities for disabled persons. (Section 41, National Assistance Act, 1948.)

Care of Mothers and Young Children and Nursing Services Sub-Committee.—The duties of the County Council in respect of Nursing Homes (Sections 187-195) and Notification of Births (Section 203), under the Public Health Act, 1936; the care of mothers and young children (Section 22), domiciliary midwifery (Section 23), health visiting (Section 24), home nursing (Section 25) and domestic help (Section 29) services under the National Health Service Act, 1946; the Nursery and Child Minders Regulation Act, 1948; and the Midwives Act, 1951.

JOINT STANDING SUB-COMMITTEE OF THE WEST RIDING HEALTH AND EDUCATION COMMITTEES

Divisional, School Health and Dental Services Sub-Committee.—All matters appertaining to the Divisional Health Administration (Section 111, Local Government Act, 1933); and the School Health and County Dental Services. (Education Act, 1944.)

STANDING SUB-COMMITTEE OF THE WEST RIDING EDUCATION COMMITTEE

Special Services Sub-Committee.—All matters appertaining to the ascertainment of handicapped pupils and the provision of special educational treatment. (Education Act, 1944.)

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INTRODUCTION

Although the body of the report relates strictly to the calendar year this introduction must of necessity range over a wider period if only for the sake of intelligent continuity.

The rapidly rising birth rate has very great significance for the health services. We were led to believe from indications then apparent that the peak birth rate of 1947, followed as it was by a rapid fall, would not be repeated. This point of view was supported by the conclusion of the Royal Commission on Population. In actual fact, as is now well known, the birth rate has risen again rapidly and is continuing to do so with no sign of diminution—it is already approaching the peak of 1947. The immediate effect, of course, is on the midwifery service, but will eventually be felt in all our services through child welfare clinics, schools, and ultimately teenager and marriage problems. For the moment, however, it is obvious that a strong domiciliary midwifery service will still need to be maintained in spite of the prospects of increased hospital provision and the tendency of earlier discharge from hospital after confinement. Ironically enough it would appear that the domiciliary services are better geared to deal with this expansion of the birth rate than the hospitals. At least we are not under any undue pressure in the West Riding at the moment.

Bearing the increased birth rate in mind as one of the bases of all our plans for the future, the present year will be remembered as a year of reappraisal of the services as a result of the Ministry's request to all local health authorities for a statement of their intentions during the next ten years. Similar plans for the hospital services had already been published and these, together with the increased birth rate, really form the foundations of the progress to be aimed at by local health authorities. The plans from every authority have now been collated and published as a Command document. The interest of this document lies in the comparisons which can be made between the plans of the various authorities and the average requirements of the country as a whole. The value of this comparison is in the opportunity it gives for the annual revision of the plan which is asked for by the Ministry. Eventually, therefore, as each year passes and adjustments are made, the plans of the hospitals and the local health authorities should get closer together in their ultimate objective of meeting the full needs of the community. A summary of the West Riding plan appears in the miscellaneous section of this report.

Perhaps the most interesting project for future development is the introduction of new categories of staff into the department in the shape of social workers and health visitor assistants. For many years we have not been able to recruit up to our establishment of health visitors. In spite of a training scheme run jointly with the City of Leeds recruitment has merely offset losses by retirement and resignation. Already the staff of health visitors includes a number of nurses without the health visitor's certificate. This has been essential in order to keep the work of the department going. I think it is over-optimistic to expect that the expansion of work in the department, and the increased volume of work placed upon the health visitor by greater stress on community care, can be met by an influx of trained health visitors. I just do not believe that the greater number required by all the authorities in the country, if we are to accept their

ten year plans, will be forthcoming. Consequently we must look around for other sources of assistance. The authority has decided to experiment in the use of nurses who are not health visitors, and who are more readily available, particularly if employed part-time, and in the use of various types of social workers as envisaged in the Younghusband Report. Experiments in this field are to proceed at once. If these experiments are to succeed a necessary corollary is an acute examination of the duties of health visitors with a view to relieving them of much routine work which could well be done by others and leave them free to exercise their skill on problems for which they were really trained. I am aware that this may cause some misgivings in the minds of some health visitors, but it is a problem which must be faced if any progress is to be made in the future. What is not easy to get over to the health visitor who has been brought up under the present régime is that her status and usefulness will be considerably increased by such changes. Such an examination of the duties of health visitors has been undertaken by a Working Party in the department, and although the recommendations are not entirely revolutionary they will act as a basis on which our experiments can proceed.

There are three main directions in which the duties of health visitors should be concentrated in the future. First of all in an increased liaison with general practitioners. This duty is becoming more obviously necessary as the years go by and as the general practitioner service and our own get closer together. Already we have started in this sphere in a few areas in the County by seconding health visitors for some of their time to groups of general practitioners to carry out social work on behalf of patients. This has been developed, particularly in Skipton, Keighley and Wath, but the more one looks into the problem the more one realises the considerable amount of liaison which has already taken place unofficially between health visitors and general practitioners. This must be stimulated further. Secondly, an important activity of the health visitor is health education. This always has been so, but it is becoming increasingly obvious that further expansion is necessary. Thirdly, I think the health visitor has a big part to play in carrying out preventive duties on specific problems.

Some of these specific problems have already got under way in the West Riding. For almost two years we have been doing a routine test on all infants in order to detect phenylketonuria and so prevent mental sub-normality. A full report of our activities appears in the body of the report. It will be obvious from this that the subject is more complex than was originally contemplated, and there are obviously many problems to be solved, but at least we have brought to the notice of the clinicians all the positive cases in the very high percentage of children tested. Here the health visitor has played a very great part and, although some of the positive cases have been found to have become normal in the course of time, her time has not been wasted. Half of the 12 cases discovered have been placed on diet and we believe that their mental condition has been stabilised. Another specific test involving the health visitors and medical staff is the introduction of the Ortolani tests for congenital hip on all infants. This scheme is in the early stages of development but has already shown worthwhile results. The health visiting staff have had their attention drawn to the very great problem of amblyopia, and efforts are being made by early detection to prevent at least some of the large numbers of squinting and blind eyes, which still go without recognition; similarly with the early detection of deafness. It is on problems such as these that the health visitor should be concentrating. I have no doubt at all that many other specific problems can be tackled in the same way. For instance, selective urine testing for diabetes detection, which is of current interest.

On the question of general practitioner co-operation, some practical steps have been taken to bring their services more physically in contact with our own. The formal health centre at Cleckheaton is now in the early building stage. On the other end of the scale the County Council have approved the building of small centres in the more sparsely populated areas, which will not only serve our own needs and those of other departments of the County Council, but in some cases may have residential accommodation for a nurse and branch surgery accommodation for general practitioners. This is part of our Ten Year programme. In between these two extremes at least one of our existing formal welfare centres is being used by a general practitioner for part of the time as his surgery headquarters with the approval of the County Council. By such measures do we hope to bring mutual assistance to both the general practitioners and our own staff.

Efforts have been made during the past year to improve the midwifery service as far as the care of the premature baby is concerned, and all midwives are undergoing a special course arranged for them by the supervisory staff and with the help of consultants. There has been considerable delay in the introduction of adequate transport facilities for premature babies because we are still experimenting in order to produce the best type of cot which will retain its temperature. We have had much disappointment in this field so far. The use of Trilene analgesia has become so popular, particularly since all the staff have been fully equipped, that the apparatus for the use of gas and air is now almost completely unused, but is being kept in reserve.

Our plan for the development of the home nursing service does not envisage any great increase in the number of home nurses at this stage. We may have to review our ideas should the clinicians decide to treat more of their cases at home, or as out-patients. The indications at the moment, however, from certain surveys which have been carried out in the Riding, would suggest that no further increase will be needed for some time. There has been a revision of the records kept by the home nurses, and this was put into operation on the 1st January, with the result that information given on the home nurses' activities are much more complete this year and will enable us better to watch the trend of development. We have at least been able to make a start on the twenty-four hour nursing service with the assistance of the Marie Curie Foundation nurses. Other helpers are employed as and when necessary at the expense of the Foundation for the care of cancer patients. The County Council have expanded this scheme at their own expense for selected terminal cases of other illnesses. The development of these facilities is still in its early stages, but where it has been put into operation it has been very much appreciated.

With the introduction of full-time nursing of certain cases, we have now theoretically a complete team which should be able to meet most situations. The team consists of midwives, home nurses, health visitors, home helps, night helps, full-time nurses, mental welfare officers, social workers and auxiliary nurses. Success, of course, will depend upon having adequate numbers at the right time. The only outstanding problem is likely to be the aged person, already mentioned in a previous report, who is unable to fit into Part III accommodation or hospital accommodation and may need constant care for a prolonged period. So far no one seems able to accept responsibility for this type of case, and in the meantime various expedencies, much to the discomfort of the patient, have been adopted.

Statistically speaking, the health of the community is progressing satisfactorily except for the vexed problem of cancer of the lung. The West Riding infant mortality is down again to the second lowest rate hitherto recorded. It will be remembered that last year we had a temporary set-back. The present low figure is also accompanied by a fall in the perinatal mortality rate so that a considerable improvement has been achieved. However, one must expect certain annual fluctuations when the rates are getting to such a low level. The tuberculosis death rate is at its lowest at 0.05 per 1,000 population, and the rate of decline during the last few years has been quickening. In an effort to step up the rate of demise of tuberculosis, meetings have been held with the chest physicians to consider future policy, and it has been decided to concentrate our efforts through the health visitors and with the approval of the local medical committee on the locating of old people, particularly men, with positive sputa. It has also been agreed to stimulate the use of skin jelly tests on school entrants as a convenient method of detecting positive reactors and so lead us to infectious cases. The jelly test is realised as not being 100 per cent. efficient but it is convenient and quicker for this purpose. Neither of these methods are new and have been used extensively in the past but it is our intention to concentrate on them now as the best means of discovering the open cases under present circumstances. Chest physicians have also agreed to notify divisional medical officers of sputum positive cases which are resistant to drugs in order that special surveillance can be arranged.

It is interesting to study the table of infectious diseases on page 48. Somehow the decline in the numbers of cases is taken for granted, and it is not readily realised what a tremendous change has taken place in recent years. Every notifiable disease has decreased in an extraordinary manner except measles, which is still present with us in large numbers. However, even here there is the possibility of preventive vaccination being made available. The odd case of diphtheria still occurs. We had one death in an unimmunised person. There was also one whooping cough death, again in an unimmunised person, and one poliomyelitis death with no record of immunisation. These stark facts speak volumes for the constant pressure which must be maintained to make people see the necessity of full protection.

Arrangements have been made with the medical officers of the Coal Board in the area for tetanus immunisation to be carried out on all miners who have attended hospitals with injuries which have necessitated their being injected with anti-tetanic serum. (This is an extension of our general scheme.) Repeated injections of this latter serum can cause some little trouble occasionally when it is necessary for miners to undergo treatment. Active immunisation, however, as now introduced will remove any danger of complications at a later date.

The smallpox epidemic of 1962 led to much work in the department and I am very grateful to all the staff for their tremendous efforts. The outcome was very successful indeed in that no third generation cases occurred, and showed the absolute value of contact tracing and vaccination as against mass vaccination which was so volubly demanded by the general public. A full account of the problems encountered and the considered views of the department are contained in the body of this report. The only practical outcome so far has been the Ministry's recommendation to carry out routine vaccination in the second year of life rather than the first year as had previously been the general policy. It is considered that this practice is much safer and it endorses the policy within the West Riding health department where this procedure had been in operation for

the last two years. The much greater principle of the total abolition of infant vaccination is still under consideration. There are many advantages both to the individual and to the community in tackling an outbreak of smallpox in a country where the disease is not endemic, by using the now well tried and proven system of ring vaccination, without the time consuming, dangerous and distracting process of mass vaccination.

Dr. Burgess, the Adviser in Venereology, has carried out an investigation with his colleagues throughout the country on the question of the follow-up of contacts. He has advocated a follow-up scheme which is used in the West Riding and which is described in this report, but I feel that I must draw attention to the fact that his investigations reveal that the essential liaison between the venereologists and the medical officers of health fails considerably in some parts of the country. In the light of the increased incidence of venereal disease this is rather disturbing, and plans should be made to ensure that the medical officer of health is kept fully informed of the situation by the venereologist in order that he may carry out his statutory duty of follow-up. Dr. Burgess's findings were published in the 'Medical Officer' of the 8th February, 1963.

Lung cancer shows no abatement in its relentless progress. It is indeed an epidemic which has by no means reached its peak yet—the rise in incidence is very rapid. In 1957 we had 473 male deaths from this condition. In 1962 this had risen to 584. In 1957 we had 66 female deaths and in 1962 this had risen to 95. Women were much later in taking up cigarette smoking than men but we are now beginning to see the results, and it is reasonable to deduce that female deaths will go on increasing and so make the present position much worse than it is. Like accidents on the road, which are also rapidly increasing, lung cancer is largely viewed with complacency in spite of the fact that people must by now know the full facts of the situation in both instances. We cannot help but compare this complacency with the near panic which was evident for mass vaccination against smallpox during the 1962 epidemic, where the chances of getting the disease were infinitesimal compared with the one in eight chances of getting lung cancer for the heavy smoker.

The Milk (Special Designation) Regulations of 1960 place a statutory duty on the County Council for the registration of dealers. Previously it had been the responsibility of district councils. This has necessitated a complete re-organisation of the public health inspectors' section of the department, which has now been authorised by the County Council. This will involve the employment of more inspectors and sampling officers and will at the same time enable other important duties to be undertaken which hitherto have not been fully developed.

The County Dental Service has been unusually successful in the recruitment of dental officers, and at the time of writing we are in a better position than we have ever been before. This does not mean, however, that we can deal with the mass of dental caries which is increasing year by year as the consumption of refined sugar goes for ever upwards. We have also employed during the year our first newly trained dental auxiliary under the Ministry's experimental scheme. This young lady has fitted very well into our service and has been doing good work. There is every possibility of more auxiliaries being available to us during the coming year. All this, however, does not meet the problem fundamentally, which can only be tackled by preventing dental caries, and some progress has been made. At least there is a possibility of tuck shops in schools serving less dangerous materials than the sticky, sugary sweets and biscuits which have been available hitherto. There is also the possibility of the introduction of fluoridation of water supplies, a badly needed measure and which the County Council have

now approved. The resistance in some quarters to this simple and safe procedure is completely baffling and quite incomprehensible in the light of the statistics. Last year West Riding children lost by extraction 70,396 teeth and 130,821 fillings were inserted. Add to this the fact that 917 children had to be supplied with dentures to wear for the rest of their lives and we have a measure of the tragedy. Now that dental treatment for expectant and nursing mothers is free under the General Dental Services (National Health Service Act, 1961) we are finding that fewer cases are coming to us for treatment. Hitherto only our service was free whereas the General Service carried a charge.

We have continued our efforts at training ambulance personnel in advanced First Aid, particularly in modern resuscitation methods, and I am given to understand that this has already borne fruit in a practical way on several occasions when the methods of resuscitation, which have been taught, have proved successful. At this stage I would like to pay tribute to the ambulance personnel who assisted all the authorities in the West Riding during the smallpox epidemic by transporting every smallpox case to hospital irrespective of the place of residence. I would also pay tribute to their patience in remaining behind the locked doors of the smallpox hospital except when they went on a mission to collect a case. Their activities were very useful in preventing the spread of the disease.

I would also like to pay tribute to the co-ordinating committees chaired by divisional medical officers for their work on problem families during the year. This has been even more welcome latterly because of the emphasis which has been placed on the prevention of eviction of families for non-payment of rent. This latter scheme is working very well.

Staff training is an essential part of any health department programme. It is well recognised that midwives and health visitors need refresher courses from time to time, and this has now been extended to other members of the staff, particularly the mental health workers, many of whom have no recognised qualifications as yet. We aim to use the facilities of courses run by outside bodies extensively, and we do a good deal of our own in-service training in addition. All this is to be encouraged in every way if we are to give an efficient service to the community.

It will be seen from the body of the report that the scope of health education is expanding rapidly each year, and the time has now been reached when extra staff must be considered for this essential function.

In the field of mental health there has been a consolidation of the plans already laid in previous years. The emphasis in the past year has been on the expansion of the industrial side of the training centres for adults. This has a great future and it has been very satisfying to see how it has grown, and will continue to grow.

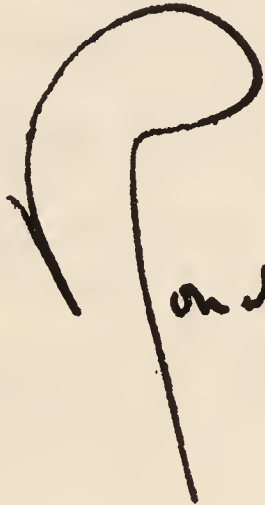
Two problems have been the source of a certain amount of pressure. First of all, the continued demand for hostels for mentally disturbed patients. We have already started on our programme of building hostels for varying types of patient, and I am quite convinced that we should see how these function before planning others. An authority the size of the West Riding may well need many more, and I should imagine that if the pilot scheme is successful we can then go ahead more rapidly, but this prior experience I am sure we must have.

Secondly, it is becoming obvious that we shall have to examine our present policy of accommodating the elderly disturbed patient. A few of them cannot be accommodated in Part III accommodation or hospital and we may need to consider the provision of a special hostel for them.

These are some of the issues which have interested the committee and staff in 1962. They show a broad field of activities and a promise for the future. In following these ideas I have gratefully received every help from members of the staff of the health department and of other departments of the County Council, as also from members of the committee. I would ask them all to accept my sincere thanks.

Health Department,
Wood Street,
Wakefield.

July, 1963.

 on 11. W. Ellis
County Medical Officer.

STAFF OF THE HEALTH DEPARTMENT

as at 31st December, 1962

MEDICAL STAFF

County Medical Officer and Principal School Medical Officer	Ronald W. Elliott, M.D., M.SC., D.P.H.
Deputy County Medical Officer	J. Lyons, M.B., CH.B., M.R.C.S., L.R.C.P., D.P.H.
Senior Administrative Medical Officers	D. E. Jeremiah, M.B., B.S., D.T.M. and H., D.P.H. P. H. Brewin, M.B., CH.B., D.P.H.
Venereologist (part-time) ...	J. A. Burgess, M.D., CH.B., D.P.H.
Pædiatrician (part-time) ...	C. C. Harvey, B.SC., M.D., B.S., F.R.C.S., M.R.C.P.
Obstetrician (Joint appointment with Hospital Services)	J. C. MacWilliam, L.R.C.P., L.R.C.S., L.R.F.P.S., D.OBST.R.C.O.G.

Divisional Medical Officers—

Division No.

1 (Skipton) ...	M. Hunter, M.B.E., M.D., CH.B., D.P.H.
3 (Keighley) ...	V. P. McDonagh, M.B., CH.B., D.P.H.
4 (Shipley) ...	J. Battersby, M.B., CH.B., D.P.H.
5 (Horsforth) ...	A. Telford Burn, M.B., B.S., D.P.H.
7 (Harrogate) ...	N. V. Hepple, M.D., B.S., B.HY., D.P.H.
9 (Wetherby) ...	R. G. Smithson, M.D., CH.B., D.P.H.
10 (Goole) ...	S. K. Appleton, M.D., CH.B., D.P.H., D.T.M.
11 (Castleford) ...	J. M. Paterson, M.B., CH.B., D.P.H.
12 (Pontefract) ...	J. F. Fraser, M.B., B.S., D.P.H., D.OBST.R.C.O.G.
13 (Morley) ...	A. Withnell, B.SC., M.D., CH.B., D.P.H.
15 (Batley) ...	J. F. Caithness, M.B., CH.B., D.P.H.
16 (Rothwell) ...	A. L. Taylor, M.D., CH.B., D.P.H., L.D.S.
17 (Spenborough) ...	W. M. Douglas, M.B., CH.B., D.P.H.
18 (Brighouse) ...	F. Appleton, M.B., CH.B., D.P.H.
19 (Todmorden) ...	N. E. Gordon, M.B., CH.B., D.P.H.
20 (Colne Valley) ...	E. Ward, M.R.C.S., L.R.C.P., D.P.H.
22 (Wortley) ...	J. Main Russell, M.B., CH.B., B.HY., D.P.H.
23 (Hemsworth) ...	J. S. Walters, M.C., M.B., CH.B., D.P.H.
25 (Barnsley) ...	R. Barnes, B.A., M.R.C.S., L.R.C.P., D.P.H.
26 (Wath upon Dearne) ...	D. J. Cusiter, M.B., CH.B., D.P.H., D.T.M. and H.
27 (Doncaster) ...	J. Ferguson, M.B., CH.B., D.P.H.
29 (Thorne) ...	G. Higgins, B.SC., M.B., CH.B., D.P.H.
31 (Rotherham) ...	J. M. Watt, M.D., CH.B., D.P.H., D.C.H., D.OBST.R.C.O.G.

Assistant County Medical Officers and School Medical Officers—

Division No.

1 (Skipton)	...	...	*Helen M. Dean, M.B., CH.B., D.P.H. *Ruth R. Stoakley, M.B., B.CH., B.A.O., D.P.H. N. W. Shephard, M.B., CH.B., D.OBST.R.C.O.G.
3 (Keighley)	...	...	*Doreen E. Gledhill, M.B., CH.B. J. I. Bennet, M.B., CH.B.
4 (Shipley)	...	...	*Gwendolen Buckle, M.B., B.S. Adaline N. Ambler, M.B., CH.B.
5 (Horsforth)	...	...	*Kathleen A. S. Brosnan, M.B., B.CH., D.OBST.R.C.O.G., D.P.H. *Helen M. Mitchell, M.B., CH.B. A. Elsworth, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H. Joan M. Murdoch, L.M.S.S.A.
7 (Harrogate)	...	...	*Gertrude M. Pullan, B.SC., M.B., CH.B., D.OBST.R.C.O.G. *Sheila F. Schofield, M.B., CH.B., D.P.H., D.C.H. P. A. G. M. Ashmore, M.R.C.S., L.R.C.P. A. W. I. Hall, M.B., B.CHIR.
9 (Wetherby)	...	...	*Elizabeth M. Hargreaves, M.B., CH.B., D.P.H. J. G. McHugh, M.B., CH.B., D.C.H.
10 (Goole)	...	...	*Muriel J. Lowe, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.C.H. Eileen M. R. Bell-Syer, M.B., B.S.
11 (Castleford)	...	...	*J. M. B. Carr, M.B., CH.B., D.P.H. Bessie J. Catton, M.B., CH.B.
12 (Pontefract)	...	...	*Eileen Atkinson, M.B., CH.B., D.OBST.R.C.O.G., D.P.M. Mercia Obadiah, M.B., B.S., D.OBST.R.C.O.G.
13 (Morley)	...	...	*Barbara Briggs, M.B., CH.B., D.P.H. Irene Hargreaves, M.B., CH.B. Mary K. Shaw, M.R.C.S., L.R.C.P.
15 (Batley)	...	...	Freda M. Cox, M.R.C.S., L.R.C.P. J. E. Lee, M.R.C.S., L.R.C.P.
16 (Rothwell)	...	...	*Ruth M. Bowker, B.A., M.B., CH.B., D.P.H. Sheila M. Dick, L.R.C.P., L.R.C.S.
17 (Spenborough)	...	...	Shirley Jessop, M.B., CH.B., D.P.H. Denise E. Robertshaw, M.B., CH.B.
18 (Brighouse)	...	...	*Marie P. Milligan, B.SC., M.B., CH.B., D.P.H. D. B. Reynolds, M.R.C.S., L.R.C.P., D.P.H.
19 (Todmorden)	...	...	*Gladys V. Bradshaw, M.B., B.S., D.OBST.R.C.O.G., D.P.H. J. J. G. Kneafsey, M.B., B.CH., D.P.H.
20 (Colne Valley)	...	...	*W. P. B. Stonehouse, M.A., M.R.C.S., L.R.C.P., D.P.H. Charlotte N. Capes, M.B., CH.B., D.P.H. A. A. Kenyon, M.B., CH.B.
22 (Wortley)	...	...	*F. C. Armstrong, M.B., B.CH., D.P.H. Hazel R. Meacock, M.B., CH.B., D.C.H.
23 (Hemsworth)	...	...	*Edith E. Cromb, M.B., CH.B., D.P.H. Josephine Hayes, M.B., CH.B. C. H. Merry, M.R.C.S., L.R.C.P.
25 (Barnsley)	...	...	*E. J. Desmond, M.B., B.CH., B.A.O., D.P.H. Stella G. A. Henriques, M.B., CH.B.

Assistant County Medical Officers and School Medical Officers—continued

- 26 (Wath upon Dearne) *Barbara R. A. Demaine, M.B., CH.B., D.P.H.
 *J. D. Hall, M.R.C.S., L.R.C.P., D.P.H.
 Mary R. Menzies, M.B., CH.B., D.C.H.
 S. K. Pande, M.B., B.S.
- 27 (Doncaster) ... *P. O. Nicholas, M.B., CH.B., D.P.H., D.C.H.
 Margaret T. Burton, B.A., L.M.S.S.A., L.M.
 Christina M. Dornan, M.B., B.CH., B.A.O.
 Amy Kropacz, L.R.C.P., L.R.C.S.
- 29 (Thorne) ... Rose B. Laidlaw-Becker, M.D., CH.B., M.R.C.S.,
 L.R.C.P., D.P.H., D.P.M.
- 31 (Rotherham) ... *M. E. O'Neill, M.B., CH.B., D.P.H.
 Margaret J. Hallinan, M.R.C.S., L.R.C.P.

109 General Medical Practitioners who act as Child Welfare Centre Medical Officers and are employed on a sessional basis. This is the equivalent of 16·6 whole-time Assistant County Medical Officers.

* Senior Assistant County Medical Officer and School Medical Officer.

Chest Physicians—(Joint Appointments with Hospital Services)—

SHEFFIELD REGION

D. H. Anderson, V.R.D., M.D., B.CH., B.A.O., D.P.H.
 F. C. N. Holden, M.D., B.S., M.R.C.S., L.R.C.P.
 A. C. Morrison, M.D., CH.B., D.P.H.
 J. D. Stevens, M.D., B.SC., M.R.C.S., L.R.C.P.

LEEDS REGION

J. Charley, M.D., B.S., M.R.C.P., M.R.C.S.
 J. J. Danaher, M.B., B.CH., B.A.O.
 R. S. Donaldson, M.D., CH.B., D.T.M., D.P.H.
 G. F. Edwards, M.B.E., M.B., B.S., M.R.C.P., M.R.C.S.
 H. Grunwald, M.D. (Vienna)
 W. D. Hamilton, M.B., B.CH., B.A.O., D.P.H.
 W. H. Helm, M.R.C.S., M.R.C.P.
 G. Henry, M.B., B.CH., B.A.O.
 D. A. Herd, L.R.C.P., L.R.C.S., L.R.F.P.S.
 J. W. Jordan, M.D., B.S., M.R.C.P., M.R.C.S.
 B. T. Mann, B.SC., M.D., CH.B., D.P.H.
 Marjorie S. Oxley, M.B., CH.B., T.D.D.
 H. E. Raeburn, M.D., B.S., L.M.S.S.A., D.P.H.
 J. K. Scott, M.B., CH.B., M.R.C.P., D.P.H.
 D. K. Stevenson, M.B., CH.B., M.R.C.P.
 J. Viner, M.B., CH.B.
 J. Y. Walker, M.B., CH.B., D.P.H.
 R. N. Walker, M.B., CH.B., D.P.H.
 A. Weleminsky, M.D. (Prague)

Other Medical Specialists in the School Health Service (Regional Hospital Board and University Appointments)—

OPHTHALMIC

H. C. Black, M.B., B.CH., B.A.O., D.O.M.S.
S. M. Kamaluddin, M.B., B.S., D.O.M.S.
J. V. Kirkwood, M.B., CH.B., D.P.H.
B. A. Marshall, M.B., CH.B., D.O.M.S.
N. L. McNeill, M.B., B.S., M.R.C.S., L.R.C.P., D.O.M.S.
K. H. Mehta, M.B., B.S., M.R.C.S., L.R.C.P., D.O.
M. A. Mirza, D.O.
S. Robertson, M.B., CH.B., D.O.M.S.
T. S. Severs, M.D., B.S., M.R.C.S., L.R.C.P.
E. S. Tan, M.B., CH.B., D.O.M.S.
C. W. Thornhill, F.R.C.S., L.R.C.P. and L.M., L.R.C.S.I. and L.M., D.O.
J. L. Wood, M.R.C.S., L.R.C.P.
P. M. Wood, M.B., CH.B., F.R.C.P., D.O.M.S.
L. Wittels, M.D. (Vienna), D.O.

ORTHOPAEDIC

J. H. Annan, M.B., CH.B., F.R.C.S.
H. N. Burwell, M.B., CH.B., F.R.C.S.
A. J. S. Bell-Tawse, M.A., M.B., F.R.C.S.
R. W. L. Calderwood, F.R.C.S.
G. F. Hird, F.R.C.S., L.R.C.P.
G. Hyman, M.B., CH.B., F.R.C.S.
P. Kilburn, M.B., CH.B., F.R.C.S., M.CH.ORTH.
W. H. Maitland-Smith, M.B., CH.B., F.R.C.S., M.CH.ORTH.
A. Naylor, M.SC., M.B., CH.M., F.R.C.S.
Miss M. A. Pearson, M.B., CH.B., F.R.C.S.
E. R. Price, M.B., B.S., F.R.C.S., M.R.C.P.
I. M. Whitwam, M.B., CH.B.
J. Wishart, M.B., CH.B., F.R.C.S.

E.N.T.

P. H. Beales, M.B., B.S., F.R.C.S.
W. M. S. Ironside, M.B., CH.B., F.R.C.S.
H. Morus-Jones, M.C., M.B., B.S., F.R.C.S., L.R.C.P., D.L.O.
S. Kavanagh, L.R.C.P.I. and L.M., F.R.C.S., D.L.O.
K. M. Mayhall, M.A., M.B., B.CHIR., F.R.F.P.S., M.R.C.S., L.R.C.P., D.L.O.
H. M. Petty, M.B., CH.B., D.L.O.
J. E. Rees, M.R.C.S., D.L.O.
W. L. Rowe, M.B., CH.B., F.R.C.S.
C. Smith, M.B., B.S., F.R.C.S., L.R.C.P., D.L.O.

PAEDIATRIC

M. W. Arthurton, M.D., M.R.C.S., M.R.C.P., B.S., D.C.H.
M. F. G. Buchanan, M.B., CH.B., F.R.C.P., D.C.H.
G. M. Lewis, M.B., CH.B., M.R.C.P., D.C.H.
J. D. Pickup, M.D., CH.B., D.C.H.
L. J. Prosser, M.B., CH.B., D.C.H.
R. J. Pugh, M.B., CH.B., M.R.C.P., M.R.C.S., D.C.H.

CARDIAC

J. R. Fountain, M.D., M.R.C.P., M.B., CH.B.
L. J. Prosser, M.B., CH.B., D.C.H.
P. C. Reynell, D.M., B.CH., M.R.C.P.
W. S. Suffern, M.D., CH.B., M.R.C.P., M.R.C.S.

DERMATOLOGICAL

W. E. Alderson, M.A., B.M., B.CH.

PSYCHIATRISTS

P. J. Crowley, M.A., M.D., D.C.H., D.P.M.
Elizabeth Gore, M.D., CH.B., D.OBST.R.C.O.G., D.P.M.
Stephanie M. Leese, B.SC., M.B., B.S., M.R.C.S., L.R.C.P., D.P.M.
J. D. Orme, M.R.C.S., L.R.C.P., D.P.M.

NURSING AND MIDWIFERY

County Nursing Officer ...	...	Doris Walker, S.R.N., S.C.M., H.V.CERT.
Deputy County Nursing Officer		Mary G. Edwards, S.R.N., S.C.M. (Part I), H.V.CERT., H.V. TUTOR'S CERT.
Area Nursing Officers ...	...	Gladys Jones, S.R.N., S.C.M., H.V.CERT., Q.I.D.N.S. Winnie Taylor, S.R.N., S.C.M., H.V.CERT., Q.I.D.N.S.
Non-Medical Supervisors of Mid-		Norena M. Everitt, S.R.N., S.C.M., M.T.D.
wives ...	...	Winifred Williamson, S.R.N., S.C.M., M.T.D.
Health Visitor Tutor ...	...	Rona E. Chambers, S.R.N., S.C.M. (Part I) H.V.CERT., H.V. TUTOR'S CERT.

- 15 Divisional Nursing Officers.
- 334 Health Visitors and School Nurses (36 part-time).
- 4 Orthopaedic Nurses and Physiotherapists (2 part-time).
- 7 Tuberculosis Visitors.
- 4 Venereal Diseases Social Workers (Qualified Health Visitors).
- 312 Home Nurses and Home Nurse/Midwives (15 part-time).
- 193 Midwives (3 part-time).
- 5 Matrons and 26 other nursing staff at 5 Day Nurseries.

MENTAL HEALTH SERVICE

Psychiatric Social Worker-Tutor	Maria Farrow, A.A.P.S.W.
Senior Mental Welfare Officers	R. Aspinall Margaret M. de la Cour A. Emmerson J. H. Hope J. G. Jarvis S. Parkinson
40 Mental Welfare Officers.	
1 Trainee Mental Welfare Officer.	
Organiser of Training ...	Frances E. Woolley, DIP.N.A.M.H.
15 Supervisors in Mental Health Training Centres.	
71 Assistant Supervisors and other assistant staff.	
6 Home Teachers for (Mentally) Subnormal Children (1 part-time).	

CHILD GUIDANCE SERVICE

Psychologists D. G. Pickles, M.A.
H. B. Valentine, M.A.
5 Psychiatric Social Workers (4 part-time).

SPEECH THERAPY SERVICE

Chief Speech Therapist ... Vacancy.
18 Speech Therapists (3 part-time).

DENTAL SERVICE

Chief Dental Officer, Principal D. Davies, M.B., CH.B., B.D.S.
School Dental Officer
Orthodontic Consultant ... Rachel Sclare, DIP.ORTH.R.C.S.(Eng.), L.D.S.
Senior Dental Officers ... W. A. Allen, B.D.S.,
J. M. Enderby, L.D.S.
M. R. Hollings, F.D.S., B.CH.D.
H. Taylor, L.D.S.
G. A. Thompson, B.CH.D.

School Dental Officers—

I. F. Ash, B.CH.D.	A. S. Metcalfe, L.D.S.
Freda Bartholomew, B.CH.D., L.D.S.	E. S. Midgley, L.D.S.
A. S. Britton, B.D.S.	S. Mitchinson, L.D.S.
G. H. Bulcock, L.D.S.	J. Naftalin, L.D.S.
Joan Cader, B.D.S.	Joyce Neden, B.D.S.
K. R. Cowell, B.CH.D.	M. S. Ormesher, B.D.S.
Joan M. Davison, L.D.S.	D. B. Owen, L.D.S.
W. H. Dyke, L.D.S.	G. B. Reid, L.D.S.
P. F. A. Eltome, L.D.S.	G. Rollinson, B.D.S.
J. D. Franks, L.D.S.	Jessie Rothera, L.D.S.
Mary M. Gibson, L.D.S.	F. H. Sanderson, L.D.S.
R. K. L. Gilchrist, B.CH.D.	Susanne E. Schloss, L.D.S.
J. F. G. Gill, L.D.S.	B. Sleight, B.CH.D.
Kathleen M. Golding, B.D.S.	P. Smith, L.D.S.
P. E. Goward, B.D.S.	G. W. Staples, B.CH.D.
J. F. Gravely, L.D.S.	D. J. Stocks, L.D.S.
M. Hattan, L.D.S.	Marian M. Thom, L.D.S.
S. Henry, L.D.S.	E. Thornton, L.D.S.
Asenath M. Holburn, L.D.S.	P. W. Thornton, L.D.S.
F. Kershaw, L.D.S.	J. Todd, L.D.S.
B. Kirkland, B.D.S.	E. B. Toulson, B.D.S.
S. Levinson, L.D.S.	J. L. Traynor, B.CH.D.
Valerie P. Lindsay, L.D.S.	A. A. Uthman, B.CH.D.
F. Lister	H. M. Yuile, L.D.S.
Margaret Lord, B.D.S.	

16 part-time

1 Dental Auxiliary
2 Dental Hygienists

Senior Dental Technician J. O. Ford

8 Technicians
2 Boy Dental Apprentices
67 Dental Surgery Assistants

PUBLIC HEALTH INSPECTORS

Chief County Public Health Inspector	...	D. Greenwood, M.A.P.H.I.
County Public Health Inspector	...	J. D. Clayton, A.R.S.H., M.A.P.H.I.

ADMINISTRATIVE AND CLERICAL

Chief Clerk	...	G. Richardson, D.P.A.
Sectional Clerks	...	J. H. Milne, D.P.A. H. Beatson. W. J. Battye. R. S. Marshall. T. Myton, D.P.A. T. R. Schofield, D.P.A.
Senior Clerks	...	E. Brown. D. Marshall, D.P.A. J. Spruce, D.P.A.

26 Divisional Senior Clerks
340 Other Clerical Staff (including part-time staff)

DOMESTIC HELPS

2,645 Domestic Helps

ANALYST

County Analyst	...	R. Mallinder, B.SC., F.R.I.C. (part-time).
Deputy County Analyst	...	J. C. Harrel, F.R.I.C. (part-time).

PART I

VITAL STATISTICS

Area and Population

Births

Deaths

VITAL STATISTICS

Area and Population:

The area and population of the aggregates of Municipal Boroughs and Urban Districts, Rural Districts, and the Administrative County are appended:—

		Municipal Boroughs and Urban Districts	Rural Districts	Administrative County
Area (acres)	... ..	380,315	1,226,599	1,606,914
Population:				
Census, 1961	...	1,187,034	464,707	1,651,741
Estimated (mid-1962)		1,200,410	476,850	1,677,260

Number of Municipal Boroughs, 13; Urban Districts, 55; Rural Districts, 21; Total 89.

Summary for 1962:

The live birth rate was 17·8; the stillbirth rate per 1,000 total births 18; the live premature birth rate per 1,000 live births was 65. The death rate from all causes was 12·0; heart and circulatory diseases 4·56; cancer 2·00; respiratory diseases 1·47; tuberculosis, respiratory 0·048; tuberculosis, other forms 0·007; diphtheria 0·001; whooping cough 0·001; measles 0·002; meningococcal infections 0·002; acute poliomyelitis 0·001 per 1,000 population. Infant mortality was 23; and maternal mortality 0·20 per 1,000 total births.

A comparison of the figures for the past 73 years is given in the following table:—

Year	Live Birth Rate	Stillbirths per 1,000 total births	Death Rates							
			All Causes	Infective and Parasitic Diseases	Tuberculosis, Respiratory	Tuberculosis, Other Forms	*Respiratory Diseases	Cancer	Maternal Mortality per 1,000 total births	Infant Mortality
1890-1909	28·9	†	16·7	1·89	1·19	0·52†	3·20	0·77†	†	147
1910-1919	22·5	†	14·5	1·26	0·84	0·41	2·58	0·98	†	112
1920-1929	20·2	†	12·4	0·56	0·68	0·25	2·08	1·20	†	82
1930-1939	15·5	46	12·1	0·30	0·48	0·13	1·24	1·46	4·70	62
1940-1949	18·1	31	12·2	0·16	0·39	0·09	1·43	1·73	1·95	47
1950-1954	15·7	25	11·9	0·09	0·19	0·03	1·23	1·89	0·82	31
1955	15·3	26	11·7	0·07	0·11	0·01	1·17	1·90	0·67	26
1956	16·4	23	11·8	0·07	0·11	0·02	1·22	1·89	0·52	27
1957	16·6	24	11·7	0·07	0·08	0·01	1·22	1·87	0·51	26
1958	16·7	23	11·9	0·05	0·09	0·01	1·29	1·97	0·43	24
1959	16·5	20	11·6	0·04	0·07	0·01	1·26	1·99	0·36	24
1960	16·9	22	11·5	0·06	0·06	0·01	1·15	1·98	0·73	22
1961	17·2	20	12·1	0·05	0·06	0·00	1·44	1·98	0·27	25
1962	17·8	18	12·0	0·04	0·05	0·01	1·47	2·00	0·20	23

* Combined death rate from bronchitis, pneumonia and other respiratory diseases excluding tuberculosis and influenza.

† Figures not available.

‡ This rate is for the 10 years 1900-1909.

Births:

Registered live births numbered 29,792, equivalent to a rate of 17·8 per 1,000 population. The number of stillbirths registered was 561 corresponding to a rate of 18·5 per 1,000 total births. Further reference to these vital events appears on page 92.

Deaths:

The number of registered deaths allocated to the Administrative County was 20,061, the highest annual total recorded since 1951. The equivalent crude death rate per 1,000 population was 12·0 compared with 12·1 in 1961 and 11·7 in the quinquennium 1957-61.

Due to the age-sex distribution of the population differing from area to area throughout the country, crude rates, although based on actual occurrences, fail to provide an accurate mortality index. To enable more realistic comparisons of the mortality between different areas to be made, compensating factors are applied to the crude rates. The death rates from all causes for the past eight years, adjusted by the appropriate factors, for the aggregates of Boroughs and Urban Districts, Rural Districts, the Administrative County, also the rates for England and Wales are given below:—

Year	Boroughs and Urban Districts	Rural Districts	Administrative County	England and Wales
1955	12·7	11·0	12·3	11·7
1956	13·1	12·0	12·9	11·7
1957	12·9	12·0	12·7	11·5
1958	13·3	12·1	13·0	11·7
1959	13·0	11·6	12·7	11·6
1960	12·9	11·9	12·6	11·5
1961	13·7	12·8	13·4	12·0
1962	13·4	12·6	13·3	11·9

PERINATAL MORTALITY:

This term is used to describe stillbirths together with deaths during the first week of life and the resultant rate expressed per 1,000 total births. In the past decade the rate has pursued a slightly downward trend and the 1962 rate of 31·5 is the lowest yet recorded. At ages 1 week up to 1 year the resultant rate was 9·9 per 1,000 total births, fractionally lower than that of the previous year, and comparing favourably with the annual average for the years since 1951 when these statistics were introduced. This group mortality is discussed further on page 96.

INFANT MORTALITY:

Deaths of infants during the first year of life numbered 695 representing a rate of 23·3 per 1,000 live births. After the setback recorded in 1961 it is satisfactory that the rate fell to the second lowest yet recorded. Details of the cause of death and the death rates at various periods under 1 year appear on pages 94 and 95.

PRINCIPAL CAUSES OF DEATH:

As in recent years the major causes, or cause groups, of death in descending order were, heart and circulatory diseases 7,651; malignant neoplasms 3,353; vascular lesions of the nervous system 3,085; diseases of the respiratory system 2,542; accidents, suicide and violence 924. In total these diseases were responsible for 17,555 deaths or 87·5 per cent. of the total mortality; their relative contribution during the past five years is indicated below:—

Percentage contribution of the five principal cause groups of death to all causes

	1958	1959	1960	1961	1962
Malignant neoplasms	16·5	17·1	17·3	16·4	16·7
Vascular lesions of nervous system ..	16·2	15·7	16·1	15·2	15·4
Heart and circulatory diseases	38·5	37·2	37·9	37·3	38·1
Diseases of respiratory system ..	11·1	12·4	10·2	13·6	12·7
Accidents, suicide and violence ..	4·6	4·8	4·8	4·5	4·6

The number of deaths classified according to cause and age appears below:—

	I Year	under 5	under 15	under 25	under 45	under 65	under 75	over	Total
1. Tuberculosis, respiratory	—	—	—	—	9	34	24	13	80
2. Tuberculosis, other	—	—	—	1	1	2	6	1	11
3. Syphilitic disease	—	—	—	—	1	6	9	7	23
4. Diphtheria	—	—	1	—	—	—	—	—	1
5. Whooping cough	1	—	—	—	—	—	—	—	1
6. Meningococcal infections	2	1	—	1	—	—	—	—	4
7. Acute poliomyelitis	—	—	—	—	1	—	—	—	1
8. Measles	1	1	1	—	—	—	—	—	3
9. Other infective and parasitic diseases	9	2	3	1	4	14	5	3	41
Total—Infective & Parasitic Diseases excl. Tub.	13	4	5	2	6	20	14	10	74
10. Malignant neoplasm, stomach	—	—	—	—	13	168	191	150	522
11. Malignant neoplasm, lung, bronchus	—	—	—	1	28	364	208	78	679
12. Malignant neoplasm, breast	—	—	—	—	35	128	81	61	305
13. Malignant neoplasm, uterus	—	—	—	—	11	61	38	16	126
14. Other malignant and lymphatic neoplasms	5	5	6	16	96	521	491	459	1,599
15. Leukæmia, aleukæmia	1	8	10	5	10	39	26	23	122
Total—All forms of Cancer	6	13	16	22	193	1,281	1,035	787	3,353
16. Diabetes	—	—	—	1	3	28	65	59	156
17. Vascular lesions of nervous system	—	1	1	4	37	456	901	1,685	3,085
18. Coronary disease, angina	1	—	—	1	83	1,220	1,325	1,298	3,928
19. Hypertension with heart disease	—	—	—	1	3	61	136	222	423
20. Other heart disease	—	1	1	3	63	294	537	1,515	2,414
21. Other circulatory disease	1	—	1	2	21	102	214	545	886
Total—Heart and Circulatory Diseases	2	1	2	7	170	1,677	2,212	3,580	7,651
22. Influenza	2	—	1	4	1	18	19	33	78
23. Pneumonia	94	17	9	4	20	98	207	531	980
24. Bronchitis	30	1	—	2	18	354	379	497	1,281
25. Other diseases of respiratory system	5	3	—	—	8	70	63	54	203
Total—Diseases of the Respiratory System	131	21	10	10	47	540	668	1,115	2,542
incl. Influenza and excluding Tuberculosis									
26. Ulcer of stomach and duodenum	—	—	—	—	6	38	35	40	119
27. Gastritis, enteritis and diarrhœa	22	11	1	2	2	13	17	27	95
28. Nephritis and nephrosis	—	1	2	5	16	49	35	41	149
29. Hyperplasia of prostate	—	—	—	—	—	7	32	67	106
30. Pregnancy, childbirth, abortion	—	—	—	—	6	—	—	—	6
31. Congenital malformations	148	12	12	9	6	18	6	2	213
32. Other defined and ill-defined diseases	355	12	15	19	62	280	220	534	1,497
33. Motor vehicle accidents	—	16	22	46	59	58	23	30	254
34. All other accidents	17	10	18	20	49	73	70	226	483
35. Suicide	—	—	—	6	31	83	44	14	178
36. Homicide and operations of war	1	—	—	2	3	—	1	2	9
Total—Accidents, Suicide and Violence	18	26	40	74	142	214	138	272	924
Total—All Causes	695	102	104	156	706	4,657	5,408	8,233	20,061

TUBERCULOSIS:

Mortality decreased further to a new record low level; there were 91 deaths compared with 108 in 1961 and an annual average of 132 in the years 1957-61. The corresponding death rates per 1,000 population were 0·05, 0·07 and 0·08 respectively. For a considerable period mortality has progressively declined; in recent years the rate of decline has quickened and while this suggests that the disease is more nearly under control it would be erroneous to imagine that it is yet defeated.

Respiratory forms of the disease accounted for 80 deaths representing a death rate of 0·05 compared with 0·06 (106) in 1961 and an annual average of 0·07 (119) in the quinquennium 1957-61. The age and sex distribution followed the pattern of recent years with males 45 years and over making the major contribution to total mortality. The combination of chemotherapy intensively applied, alert contact tracing, B.C.G. vaccination, diagnostic radiological services, improved nutrition and environmental conditions have effected remarkable improvements in incidence and mortality yet their success must not be permitted to engender apathy nor encourage any relaxation of effort. Diligent application of all measures will still be necessary for many years if complete eradication is to be achieved.

Deaths from other forms numbered 11, equivalent to a death rate of 0·007 compared with a rate of 0·001 based on 2 deaths in 1961 and an annual average of 0·008 from 13 deaths in 1957-61. The number of deaths is now so low that fluctuations of this order are of no significance. The whole of the Administrative County is now included in "Specified Areas" which means that all retailed milk is restricted to pasteurised, sterilised or tuberculin tested. This measure, together with the general scheme of elimination of bovine tubercle in dairy herds, should assist further in the curtailment of infection.

INFECTIVE AND PARASITIC DISEASES:

The number of deaths assigned to this group totalled 74 compared with 79 in the previous year and an annual average of 86 for the years 1957-61; the corresponding death rates were 0·04, 0·05 and 0·05 respectively.

In comparison with 1961 there were notable variations in mortality; reductions were recorded for poliomyelitis which decreased from 6 to 1, measles from 8 to 3, syphilitic disease from 24 to 23, and meningococcal infection from 5 to 4; whooping cough claimed the same mortality (1); while after seven years of absence of deaths from diphtheria it is regrettable having to report one death. The number of deaths assigned to the residual group "other infective and parasitic diseases" increased from 35 to 41 but unfortunately the classification of deaths to individual diseases within the group is not available.

Syphilitic disease continues as a public health problem. The majority of deaths were of persons aged 65 years or over and it is satisfactory that for the past 11 years there has been no death under one year; this is a tribute to the vigilance which is exercised at antenatal clinics. The single death from diphtheria was of a five year old unimmunised boy; the case was thoroughly investigated but the source of infection was undiscovered. The death from whooping cough was a girl of 8 months who had not commenced her course of immunisation. Meningococcal infection remains the most fatal of the common infectious diseases; of the 4 deaths 2 were of infants under 1 year, the age at which diagnosis is notoriously difficult. Only one death from poliomyelitis was recorded. This

was an unvaccinated man of 43, a caravan dweller. At the time of his admission to hospital he was residing in a County Borough and the appropriate investigations were undertaken by the Medical Officer of Health. During his stay in hospital the caravan was moved into the Administrative County and, consequently, the allocation of his death.

CANCER:

Deaths ascribed to this group, including leukæmia, numbered 3,353 corresponding to a death rate of 2·00 per 1,000 population compared with 3,283 deaths (1·93) in 1961 and an annual average of 3,214 (1·96) in the quinquennium 1957-61. The disease, being mainly associated with middle and old age, can be expected to take an increasing toll in our ageing population for there is, as yet, no indication of the rising trend being arrested. Indeed, one death in every six was certified to this group at an average of 64 persons per week.

As will be seen from the following table, the relative contribution to mortality from the separately classified sites has not changed during the past 6 years; lung and bronchus was the site most frequently concerned, followed by, in descending order, stomach, breast and uterus.

Year		Stomach	Lung, Bronchus	Breast	Uterus	Other Mal- ignant and Lymphatic Neoplasms	Leukæmia, Aleukæmia	Total all Sites
1957	M.	301	473	2	—	832	39	1,647
	F.	216	66	296	144	638	38	1,398
	T.	517	539	298	144	1,470	77	3,045
1958	M.	307	467	2	—	823	57	1,656
	F.	228	82	315	178	721	32	1,556
	T.	535	549	317	178	1,544	89	3,212
1959	M.	318	556	1	—	839	46	1,760
	F.	250	62	263	161	729	30	1,495
	T.	568	618	264	161	1,568	76	3,255
1960	M.	295	505	3	—	905	48	1,756
	F.	225	77	316	152	707	40	1,517
	T.	520	582	319	152	1,612	88	3,273
1961	M.	300	564	6	—	804	44	1,718
	F.	213	103	309	146	761	33	1,565
	T.	513	667	315	146	1,565	77	3,283
1962	M.	274	584	1	—	871	54	1,784
	F.	248	95	304	126	728	68	1,569
	T.	522	679	305	126	1,599	122	3,353

The upward trend of mortality from lung cancer continued; there were 679 deaths which again is the highest annual total recorded. Whereas a decade ago the rise was confined to males it is now becoming evident among females. Male excess mortality, however, obtained throughout all age groups and in total was in the ratio of 6:1.

The report of the Royal College of Physicians “ Smoking and Health ” provided yet further evidence that cigarette smoking is the most important cause of lung cancer. Although other avenues for further investigation, especially in regard to atmospheric pollution, are being pursued none so far has cast any

serious doubt as to the prime causative factor. Our already intensive propaganda measures received further impetus with the introduction of the Central Council for Health Education's mobile units. The Minister of Health when launching the operation of the units commented:—

“ The behaviour of the public is often paradoxical. But never has it been more paradoxical than in the face of the facts about lung cancer and smoking. When there were a few cases of smallpox earlier in the year people flocked to be vaccinated though the chances were only one in a million. Yet the same people day after day incurred deliberately and with seeming indifference chances as high as 1 in 9 or worse that they would die of lung cancer.”

Our participation in the programme of one of the mobile units and our propaganda efforts generally are discussed in the Health Education part of the Report appearing on page 131.

The number of deaths assigned to malignancy of stomach, breast and uterus varies from year to year with no trend apparent. Leukæmia mortality reached the highest annual total yet recorded. The hazard associated with radiation has been recognised and research into this and other possible causative factors continues.

The survey into the ætiology of childhood malignancies conducted by Dr. Alice Stewart of the Department of Social Medicine at Oxford University referred to in my Report last year has concluded and we eagerly look forward to the publication of her findings.

VASCULAR LESIONS OF THE NERVOUS SYSTEM:

Deaths assigned to this group numbered 3,085, equivalent to a death rate of 1·84 per 1,000 population and constituted 15·4 per cent. of the total deaths from all causes. As for other diseases associated with middle and older ages, mortality pursued an upward trend and it is significant that since 1950 mortality has increased by 20 per cent. At ages under 45 years deaths numbered 43, in the 45-64 years age group 456 (14·8 per cent. of the total deaths from this cause), at ages 65-74, 901 (29·2 per cent.) and 75 years or over 1,685 (54·6 per cent.). At ages up to 64 years there was a slight excess of male mortality but thereafter female deaths predominated.

HEART AND CIRCULATORY DISEASES:

Numerically, this group carries the highest mortality year by year. In some years the sub-groups show declining numbers but coronary disease retains its major role and continues to exact its high and steadily increasing toll. Total deaths numbered 7,651, the highest annual total recorded compared with 7,455 in the previous year and an annual average of 7,232 in the period 1957-61; the resultant death rates were 4·56, 4·50 and 4·41 respectively. The majority of deaths were of middle aged and elderly people; 75·7 per cent. were aged 65 years or over and 21·9 per cent. at ages 45-64 years. Male excess mortality was in evidence at all ages under 75 years, being especially pronounced in the 45-64 years age group, while at ages 75 years and upwards female deaths were in the majority.

Coronary disease and angina was responsible for higher mortality than any other disease; it caused 3,928 deaths, 333 greater than in the previous year and 580 more than the annual average for 1957-61. In perspective, of the total deaths all causes one in every five was due to this disease. As usual there was

a male excess of mortality extending up to 74 years with a preponderance in the 45-64 years age group. These latter deaths comprise 31·7 per cent. of the total male mortality at these ages.

The number of deaths from the other separately classified sites fluctuates with no significant trend apparent as will be seen from the following table:—

Year	Coronary disease, angina		Hypertension with heart disease		Other heart disease		Other circulatory disease		Total	
	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate
1956	2,960	1·83	471	0·29	2,964	1·83	835	0·52	7,230	4·47
1957	3,024	1·86	433	0·27	2,748	1·69	773	0·48	6,978	4·30
1958	3,367	2·07	508	0·31	2,765	1·70	844	0·52	7,484	4·59
1959	3,238	1·98	413	0·25	2,582	1·58	823	0·50	7,056	4·31
1960	3,516	2·13	415	0·25	2,351	1·42	905	0·55	7,187	4·35
1961	3,595	2·17	405	0·24	2,523	1·52	932	0·56	7,455	4·50
1962	3,928	2·34	423	0·25	2,414	1·44	886	0·53	7,651	4·56

DISEASES OF THE RESPIRATORY SYSTEM:

These causes—influenza, pneumonia, bronchitis and other diseases of the respiratory system—were responsible for 2,542 deaths compared with 2,717 in 1961 and an annual average of 2,277 in the quinquennium 1957-61; the corresponding death rates per 1,000 population were 1·52, 1·64 and 1·39 respectively. Deaths from individual causes were influenza 78 (327 in 1961), pneumonia 980 (939), bronchitis 1,281 (1,278), and other diseases of the respiratory system 203 (173).

In December, 1961, there was a period of severe weather and a number of minor outbreaks of influenza was reported in the north of the Riding; this pattern persisted until the end of January but throughout 1962 no outbreak of any significance arose. Mortality was in step with incidence and the majority of the 78 deaths directly attributed to influenza were of persons aged 65 years or over.

Incidence of pneumonia was again highest during the first quarter. Although the disease continues as a major cause of death in many instances it is a secondary rather than primary cause. Mortality was heavy among infants under 1 year (10 per cent.), at ages 65-74 years (21 per cent.) and ages 75 years or over (54 per cent.).

Chronic bronchitis has long been recognised as a common disabling disease in this country and for a number of years mortality in the County has remained relatively stable around 1,100 each year. In 1962, deaths numbered 1,281, the highest annual total since 1951. The pattern established in recent years was again in evidence, mortality being comparatively high in infants under 1 year, negligible at ages to 44 years, thereafter progressively increasing. Male excess mortality continued in the ratio of 2:1. The national death rate remains among

the highest in Europe and since the disease is positively associated with two British characteristics—air pollution and the widespread habit of smoking—control of the disease appears obvious. Medical Officers of Health are indeed persisting with the task of enforcing and introducing further smoke control areas and, as referred to elsewhere, our already intensive propaganda efforts to wean the smoker from his addiction are being further stimulated.

MATERNAL MORTALITY:

The number of deaths from the group, pregnancy, childbirth and abortion, decreased further to 6, equivalent to a rate of 0.20 per 1,000 total births; both mortality and rate are the lowest yet recorded in the Administrative County. Slight fluctuations from the individual causes are apparent from year to year and details of the classification are given on page 99.

VIOLENCE:

There were 924 deaths due to accidents and violence, the highest total recorded in the period since the revised classification of deaths was introduced in 1950. Deaths from the separately classified causes were motor vehicle accidents 254 (266 in 1961), other accidents 483 (450), suicide 178 (183), homicide and operations of war 9 (7).

Medical Officers of Health have continued to supply details of fatal home accidents and the relative frequency of these deaths, also others assigned to the various violent causes during the past eight years, are given in the subjoined table:—

Year	Motor Vehicle Accidents	Accidents in the Home	All other Accidents	Suicide	Homicide and Operations of War	Total Accidents, Suicide, Homicide
1955	177	240	267	183	12	879
1956	188	244	258	182	8	880
1957	175	245	228	214	15	877
1958	205	237	256	186	3	887
1959	204	264	252	186	13	919
1960	241	255	209	192	11	908
1961	266	248	202	183	7	906
1962	254	292	191	178	9	924

Motor vehicle accidents continued to exact their high toll of life. The number of deaths was the second highest annual total recorded since statistics for this group have been separately classified. The age-sex distribution was similar to that of recent years with excess male mortality in the ratio of 3:1 and the majority of deaths occurring in the 15-44 years age group. It is indeed a depressing thought that at ages 15-24 years 35 per cent. of all male deaths were caused by motor vehicle accidents.

Other deaths by accident were more frequent than in the two previous years, the increase being due to accidents in the home. That these deaths constitute a major public health problem cannot be emphasised too frequently and our propaganda efforts are being intensified in an endeavour to achieve reductions. Fatalities in the home far exceed those from certain diseases which create public apprehension but whether it be lack of sensationalism, apathy, or whatever the reason, opinion seems largely oblivious to this toll of life. Cold statistics indicate the extent of fatalities and disability but they can never measure the full tragedy to the families concerned. Life will always be dangerous but it is our responsibility to educate the public to keep hazards to a minimum.

The principal causes of fatal home accidents are indicated in the following table:—

Cause of Death	Age at Death — Years						
	Under 1	1-4	5-44	45-64	65-74	75 and over	All Ages
Accidental poisoning by solid and liquid substances ... { M.	—	—	2	4	—	—	6
... { F.	—	—	2	4	2	2	10
Accidental poisoning by gases and vapours ... { M.	—	—	1	2	2	2	7
... { F.	—	—	1	3	5	15	24
Accidental falls ... { M.	—	1	—	3	9	35	48
... { F.	—	1	1	4	21	101	128
Accidents caused by burns and scalds ... { M.	1	—	3	3	1	5	13
... { F.	—	3	2	2	3	11	21
Inhalation of food or vomit ... { M.	3	1	1	3	1	1	10
... { F.	3	—	1	1	—	—	5
Accidental mechanical suffocation ... { M.	7	—	3	—	—	—	10
... { F.	3	—	1	—	—	—	4
Other and unspecified accidents { M.	—	—	1	1	—	—	2
... { F.	—	—	2	1	—	1	4
Total ... { M.	11	2	11	16	13	43	96
... { F.	6	4	10	15	31	130	196

Mortality was heaviest at the extremes of life; 6 per cent. of the deaths were under 1 year and 59 per cent. at ages 75 years or over.

Falls were the major cause, being responsible for 176 or 60 per cent. of the total home accidents. Females were more frequently the victims especially at ages 75 years or over. Many of the falls were returned as “ unspecified ” which is a reflection of the number of those elderly people who lived alone.

Burns and scalds were the second highest contributor with 34 deaths; fatalities from burns increased as compared with recent years, coal fires being responsible for 9 deaths, electric and gas fires 3, and other burns 19. Of the latter deaths 4 were associated with smoking, 2 of whom paid the penalty for smoking in bed.

The third highest cause was accidental poisoning by gases and vapours which contributed 31 deaths. Old people were most frequently concerned, dying from coal gas poisoning. Failure of recent memory and impaired sense of smell were probably the underlying causes which emphasise the need for continued research into the production of a non-toxic domestic gas. The large-scale trials now being conducted by the Gas Council give rise to cautious optimism that in the not too distant future the carbon monoxide content will be reduced to a safe level.

Accidental poisoning by solid and liquid substances continued at a high level. Sixteen deaths were recorded mostly from barbiturates or their derivatives.

Fatalities from inhalation of food or vomit, 15 deaths, and accidental mechanical suffocation, 14, were more frequent than in recent years. Of the latter deaths 10 were of infants under 1 year, five of whom suffocated in their cots or prams in association with pillows or bedclothes, and three died from overlaying whilst in bed with parents.

Suicides numbered 178, slightly fewer than in the seven previous years and comparing favourably with the annual average in the period 1957-61 of 192. The distribution of deaths according to age, sex and external agent employed is given in the table appended:—

External Agent				Age at Death — Years						
				Under 15	15-24	25-44	45-64	65-74	75 and over	All ages
Domestic gas poisoning	...	{	M.	—	3	8	29	11	5	56
			F.	—	1	6	15	9	4	35
Other poisoning	...	{	M.	—	1	4	9	1	—	15
			F.	—	—	3	10	10	1	24
Hanging or strangulation	...	{	M.	—	—	3	5	4	2	14
			F.	—	—	1	3	—	—	4
Drowning	...	{	M.	—	—	2	4	2	—	8
			F.	—	—	—	2	1	—	3
Firearms	...	{	M.	—	—	4	1	1	—	6
			F.	—	—	—	—	—	—	—
Cutting instruments	...	{	M.	—	—	—	1	1	—	2
			F.	—	—	—	—	—	—	—
Jumping before or lying in path of trains	...	{	M.	—	1	—	1	1	1	4
			F.	—	—	—	—	—	—	—
Jumping from high places	...	{	M.	—	—	—	—	1	—	1
			F.	—	—	—	—	—	—	—
Other agents	...	{	M.	—	—	—	—	—	—	—
			F.	—	—	—	3	2	1	6
Total—all agents	...	{	M.	—	5	21	50	22	8	106
			F.	—	1	10	33	22	6	72

As in previous years the vehicle most frequently employed was domestic gas; of the total male suicides 53 per cent. used this agent as did 49 per cent. of the total females. Other forms of poisoning accounted for 39 deaths; 29 from barbiturates and their derivatives, 5 from aspirin and 5 in a wide range from cyanide to liniment. Hanging or strangulation claimed 18 deaths and drowning 11, again with male excess in all age groups. Polythene bags have long been recognised as a home accident hazard, but so far as is known they had not been used previously by ‘successful’ suicides; two cases were reported, one of whom also tied a stocking round her neck to effect asphyxia.

Seasonally, there was the usual high incidence in April (24) but contrary to expectations mortality during the month of October was comparatively light (11), and the secondary peak did not occur until December (20).

As mentioned previously, the research being undertaken by the Gas Council may shortly result in a reduction in the toxic content of domestic gas and we may well expect a diminution in the number of suicides until another vehicle comes into vogue to replace this disastrously effective agent.

It is recognised that social isolation may be an incriminating factor in the incidence of suicide and although information is not available as to the number of suicides who were living alone at the time of death, six of the females were spinsters and 25 were widows.

CHILD MORTALITY:

Mortality of children aged 1-4 years showed no significant change of trend. 102 deaths were registered compared with 105 in 1961 and an annual average of 95 in the quinquennium 1957-61. The corresponding death rates were 0·93, 0·98 and 0·93 respectively.

Control, or near control, over the traditional childhood diseases has left accidents, pneumonia, cancer and diarrhoea as the major causes of death in this age group.

The table overleaf gives, for certain periods, the number of childhood deaths allocated to the various causes, also the equivalent death rates.

Over the years covered by the table the number of deaths from accidents has fallen but recently the rate of decline has been very slow. Of the 26 deaths in 1962, 16 were from motor vehicle accidents and 6 from home accidents. Of these latter deaths, two were accidental falls, two were from scalds—a teapot and a jug of hot milk—one from burns and one from inhalation of food.

Deaths from cancer numbered 13 of which 8 were from leukæmia, the highest total yet recorded at these ages.

Cause of Death	Annual Averages for Quinquennia							1960	1961	1962
	1911-15	1927-31	1935-39	1940-44	1945-49	1950-54	1955-59			
Measles	439	107	27	18	10	4	2	—	4	1
Whooping cough	167	67	29	20	11	5	1	1	—	—
Diphtheria	110	47	51	32	5	1	—	—	—	—
Other infective and parasitic diseases, excluding tuberculosis	54	45	18	13	7	9	7	5	3	3
Tuberculosis, respiratory	47	13	5	4	4	1	—	—	1	—
Tuberculosis, other	201	82	37	39	30	11	2	1	—	—
Cancer	3	5	4	6	4	9	9	7	11	13
Heart and circulatory diseases	4	3	2	1	1	—	1	1	1	1
Influenza	6	43	10	11	4	2	2	—	2	—
Pneumonia	457	321	121	85	42	19	14	9	14	17
Bronchitis	150	42	10	17	9	6	6	5	10	1
Other diseases of respiratory system	49	15	6	5	3	2	2	2	—	3
Diarrhoea and other digestive diseases	248	45	38	23	17	4	4	2	3	11
Congenital debility, malformations	12	9	7	10	12	13	12	12	10	12
Accidents	82	54	50	47	38	27	23	29	25	26
Other causes	323	119	52	45	30	23	12	23	21	14
All causes	2,352	1,017	467	376	227	136	97	97	105	102
Death rate per 1,000 living in the age group ...	17.13	10.62	5.09	4.17	2.23	1.29	0.99	0.92	0.98	0.93

PART II

DIVISIONAL ADMINISTRATION

DIVISIONAL ADMINISTRATION

Twenty-three health divisions have continued to operate throughout the year and details of each division are given in the following table.

Div. No.	County Districts	Population (Estimated Mid. 1962)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional or Area Nursing Officer	Address of Divisional Health Office
1	Barnoldswick U. Earby U. Silsden U. Skipton U. Bowland R. Sedbergh R. Settle R. Skipton R.	10,250 5,150 5,230 13,080 4,740 3,710 13,780 23,900	2,764 3,519 7,101 4,211 83,327 52,674 152,087 146,071	Dr. M. Hunter Mr. K. A. Knowles Miss F. Stevenson	Water Street, Skipton Tel. Skipton 2438/9
		79,840	451,754		
3	Keighley B.	56,070	23,611	Dr. V. P. McDonagh Mr. A. S. Sanderson Miss J. Butterworth	3, Bow Street, Keighley Tel. Keighley 2244/5
4	Baildon U. Bingley U. Denholme U. Shipley U.	12,380 22,990 2,580 29,880	2,831 11,418 2,536 2,184	Dr. J. Battersby Mr. F. G. Falkingham Miss M. Tattersall	P.O. Box 24, Town Hall, Shipley Tel. Shipley 51363
		67,830	18,969		
5	Pudsey B. Aireborough U. Horsforth U. Ilkley U. Otley U. Wharfedale R.	35,980 27,920 15,530 18,360 11,750 7,090	5,323 6,856 2,706 8,610 2,934 39,378	Dr. A. Telford Burn Mr. A. Hartley Miss D. Topley	The Green, Horsforth Tel. Horsforth 2252
		116,630	65,807		
7	Ripon City Harrogate B. Knaresborough U. Nidderdale R. Ripon and Pateley Bridge R.	10,540 56,790 9,360 15,900 13,230	1,812 8,320 2,494 75,009 124,861	Dr. N. V. Hepple Mr. L. R. Wilkinson Miss M. L. Griffin	Municipal Offices, Harrogate Tel. Harrogate 5031
		105,820	212,496		
9	Tadcaster R. Wetherby R.	27,960 23,300	72,987 64,424	Dr. R. G. Smithson Mr. F. H. Attack Miss G. Jones (Retired 31/12/62)	Hallfield Lane, Wetherby Tel. Wetherby 2738
		51,260	137,411		
10	Goole B. Selby U. Goole R. Selby R.	18,860 10,500 8,660 6,580	1,267 3,848 36,776 32,909	Dr. S. K. Appleton Mr. R. Towell Mrs. W. Taylor	6/7, Belgravia, Goole Tel. Goole 936/7
		44,600	74,800		

Div. No.	County Districts	Population (Estimated Mid. 1962)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional or Area Nursing Officer	Address of Divisional Health Office
11	Castleford B. Normanton U.	40,420 18,510	4,394 3,067	Dr. J. M. Paterson Mr. C. R. Pickering Miss M. E. Thomas	"Castledene," Pontefract Road, Castleford Tel. Castle- ford 4201
		58,930	7,461		
12	Pontefract B. Featherstone U. Knottingley U. Osgoldcross R.	27,960 14,820 11,420 8,050	4,865 4,424 2,835 33,954	Dr. J. F. Fraser Mr. W. Carver Mrs. W. Taylor	Baghill House, Walkergate, Pontefract Tel. Pontefract 3291
		62,250	46,078		
13	Morley B. Ossett B. Horbury U. Wakefield R.	41,400 15,180 8,710 20,960	9,494 3,333 1,280 21,344	Dr. A. Withnell Mr. A. Wright Miss A. M. Seelig	Windsor House, Morley Tel. Morley 4281/2
		86,250	35,451		
15	Batley B. Heckmondwike U.	39,890 8,520	4,457 696	Dr. J. F. Caithness Miss K. Lister Miss G. Jones (Retired 31/12/62)	Market Place, Batley Tel. Batley 666
		48,410	5,153		
16	Garforth U. Rothwell U. Stanley U.	15,400 26,030 17,200	4,020 10,698 4,866	Dr. A. L. Taylor Mr. S. Hobson Miss G. Jones (Retired 31/12/62)	Oulton Lane, Rothwell Tel. Rothwell 2326/7
		58,630	19,584		
17	Spenborough B. Mirfield U.	37,160 12,810	8,251 3,394	Dr. W. M. Douglas Mr. P. Marshall Miss G. Jones (Retired 31/12/62)	Elm Bank, Bradford Road, Cleckheaton Tel. Cleck- heaton 2331/2
		49,970	11,645		
18	Brighouse B. Elland U. Queensbury and Shelf U.	31,260 18,320 9,370	7,873 5,946 2,795	Dr. F. Appleton Mr. G. O. Richardson Miss C. J. Barker	Mill House, Huddersfield Road, Brighouse Tel. Brighouse 796
		58,950	16,614		
19	Todmorden B. Hebden Royd U. Ripponden U. Sowerby Bridge U. Hepton R.	17,300 9,380 4,940 17,350 3,710	12,789 7,084 13,289 5,763 21,758	Dr. N. E. Gordon Mr. H. Marshall Miss D. M. E. Goldthorpe	Abraham Ormerod Medical Centre, Todmorden Tel. Todmorden 382
		52,680	60,683		
20	Colne Valley U. Denby Dale U. Holmfirth U. Kirkburton U. Meltham U. Saddleworth U.	21,250 9,450 18,510 18,240 5,510 17,320	16,054 10,165 17,648 13,847 5,906 18,485	Dr. E. Ward Mr. G. A. Beatson Miss M. P. Bramley	"Woodville," Scar Lane, Golcar Tel. Milns- bridge 933/4
		90,280	82,105		

Div. No.	County Districts	Population (Estimated Mid. 1962)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional or Area Nursing Officer	Address of Divisional Health Office
22	Hoyland Nether U. Penistone U. Stocksbridge U. Penistone R. Wortley R.	15,830 7,130 11,110 7,360 50,050	1,998 5,593 4,630 29,002 48,698	Dr. J. Main Russell Mr. T. D. Lund Mrs. M. Craig	Mortomley Hall, High Green, nr. Sheffield Tel. High Green 292
		91,480	89,921		
23	Hemsworth U. Hemsworth R.	14,530 52,400	4,163 29,019	Dr. J. S. Walters Mr. G. Ellis Miss J. Crossfield	Adiscombe House, Barnsley Road, Hemsworth Tel. Hems- worth 377/8
		66,930	33,182		
25	Cudworth U. Darfield U. Darton U. Dodworth U. Royston U. Wombwell U. Worsbrough U.	9,100 6,890 14,320 4,120 8,570 18,950 14,950	1,746 2,018 4,717 1,857 1,423 3,838 3,420	Dr. R. Barnes Mr. L. S. Wrigg Miss C. Janse	33 Queen's Road, Barnsley Tel. Barnsley 2247/8
		76,900	19,019		
26	Conisbrough U. Dearne U. Mexborough U. Rawmarsh U. Swinton U. Wath upon Dearne U.	17,740 26,640 16,900 19,640 13,740 15,260	1,593 3,888 1,452 2,600 1,718 2,677	Dr. D. J. Cusiter Mr. P. Goddard Miss V. Dunford	Dunford House, Wath upon Dearne Tel. Wath 2251/2
		109,920	13,928		
27	Adwick le Street U. Bentley with Arksey U. Tickhill U. Doncaster R.	18,270 23,160 2,600 68,830	3,605 4,950 5,580 75,093	Dr. J. Ferguson Mr. C. W. Vallance Mrs. A. Corless	Station Road, Doncaster Tel. Doncaster 61571
		112,860	89,228		
29	Thorne R.	35,760	38,419	Dr. G. Higgins Mr. J. T. Howitt Mrs. W. Taylor	Council Offices, P.O. Box 4, Thorne Tel. Thorne 3130
31	Maltby U. Kiveton Park R. Rotherham R.	14,130 19,880 61,000	4,788 20,070 28,739	Dr. J. M. Watt Mr. A. Hill Mrs. A. Brooks	"Edenthorpe," Grove Road, Rotherham Tel. Rother- ham 3131/2
		95,010	53,597		

Meetings of Divisional Medical Officers have been held each month (except August) in accordance with recognised procedure. Liaison with general practitioners has been maintained through the Standing Sub-Committee on Co-operation which met on three occasions during the year to consider the following matters.

March

- (a) The Care of Premature Infants.
- (b) Disposable Enemas.
- (c) Ten Year Development Plan for Local Health Authorities.
- (d) Wakefield and District Physiotherapy Service.
- (e) Oral Poliomyelitis Vaccine.
- (f) Supply of F.T. and T.A.F. to General Practitioners.
- (g) Dental Care for Expectant and Nursing Mothers.
- (h) Smallpox Vaccination Records.

June

- (a) Ten Year Development Plan of Local Health Authority Services.
- (b) Geriatric Preventive Clinics.
- (c) Poliomyelitis.
- (d) Reference of Expectant and Nursing Mothers to County Dental Clinics.
- (e) Tetanus Immunisation by Industrial Medical Officers.
- (f) Modification of Immunisation and Vaccination Schedule.
- (g) Smoking and Lung Cancer and Health Education in General.
Publicity in General Practitioners' Surgeries.
- (h) Thalidomide.
- (i) Pethidine in Maternity Homes.

November

- (a) Annual Report of the County Medical Officer for 1961.
- (b) Domiciliary Chiropody Treatment.
- (c) Routine Tests for Congenital Dislocation of the Hip.
- (d) Incidence of Phenylketonuria in the West Riding Administrative Area.
- (e) Thalidomide Babies.
- (f) The Register of " At Risk " Infants.
- (g) Oral Poliomyelitis Vaccination.
- (h) Immunisation of Coal Miners against Tetanus.
- (i) Items of Interest from the Monthly Bulletin of the Ministry of Health.
- (j) Notification of Commencement of Labour to General Practitioners by Midwives.
- (k) " Quadrilin " (Quadrivalent vaccine).
- (l) Vaccination against Smallpox.
- (m) Prolonged Absence from School.
- (n) Amblyopia.

PART III

EPIDEMIOLOGY

Notification of Infectious Disease
Vaccination and Immunisation

TUBERCULOSIS

VENEREAL DISEASES

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease:

Smallpox, cholera, diphtheria, membranous croup, erysipelas, scarlet fever, and the fevers known by any of the following names, typhus, typhoid, enteric, or relapsing, are compulsorily notifiable under Section 144 of the Public Health Act, 1936; chicken-pox is notifiable under Section 147 of the same Act in some West Riding County Districts; food poisoning under Section 26 of the Food and Drugs Act, 1955. The following communicable diseases are compulsorily notifiable under the regulations stated in parentheses—measles and whooping cough (Measles and Whooping Cough Regulations, 1940); meningococcal infection, acute poliomyelitis—paralytic and non-paralytic, and acute encephalitis—infective and post-infectious (Acute Poliomyelitis, Acute Encephalitis and Meningococcal Infection Regulations, 1949); ophthalmia neonatorum (Ophthalmia Neonatorum Regulations, 1926, 1928 and 1937); puerperal pyrexia (Puerperal Pyrexia (Amendment) Regulations, 1954); tuberculosis (Tuberculosis Regulations, 1952); malaria, dysentery and acute primary and influenzal pneumonia (Public Health (Infectious Diseases) Regulations, 1953); plague (Notification of Case of Plague (General) Regulations, 1900). Anthrax became notifiable as from 1st December, 1960, under the provisions of the Public Health (Infectious Diseases) Amendment Regulations, 1960. The contagious diseases of syphilis, gonorrhoea and soft chancre (classed under the term venereal diseases) and scabies are not compulsorily notifiable.

The following summary shows the number of notifications in 1962 of each notifiable disease, being the number of cases originally notified and the final numbers after revision of diagnosis.

Age Group	FEVER		COUGH		POLIOMYELITIS (PARALYTIC)		POLIOMYELITIS (NON-PARALYTIC)		MEASLES		DIPHTHERIA		DYSENTERY		INFECTION	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified ...	314	343	118	124	5	4	—	2	5,793	5,692	1	—	679	685	12	9
(All ages)	657		242		9		2		11,485		1		1,364		21	
Final numbers after correction																
Under 1 year ...	3	2	15	17	—	—	—	—	193	179	—	—	28	20	3	1
1—2 years ...	4	4	10	12	—	1	—	—	525	494	—	—	34	27	2	—
2—3 „ ...	17	17	17	23	—	—	1	—	712	690	—	—	42	47	—	—
3—4 „ ...	27	27	17	16	1	—	—	—	728	766	—	—	27	25	2	1
4—5 „ ...	35	42	9	15	—	1	—	—	818	794	—	—	27	33	—	1
5—9 „ ...	175	178	44	38	2	—	1	—	2,634	2,540	1	—	142	142	1	1
10—14 „ ...	32	58	5	2	—	1	—	—	139	160	—	—	33	42	1	2
15—24 „ ...	16	8	—	—	—	—	—	—	21	35	—	—	16	40	1	2
25 and over ...	2	2	—	1	1	—	—	—	10	18	—	—	90	92	1	1
Age unknown ...	—	3	—	—	—	—	—	—	12	17	—	—	7	6	—	—
Total (all ages) ...	311	341	117	124	4	3	1	2	5,792	5,693	1	—	446	474	11	9
	652		241		7		3		11,485		1		920		20	
Age Group	ACUTE PNEUMONIA		SMALLPOX		ACUTE ENCEPHALITIS (INFECTIVE)		ACUTE ENCEPHALITIS (POST-INFECTION)		TYPHOID FEVER		PARATYPHOID FEVERS		ERYSIPELAS		FOOD POISONING	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified ...	335	249	2	1	2	1	2	2	—	2	2	9	29	27	68	58
(All ages)	584		3		3		4		2		11		56		126	
Final numbers after correction																
Under 5 years ...	53	47	—	1	1	—	1	2	—	—	—	3	—	—	10	13
5—14 „ ...	33	31	1	—	—	1	—	—	—	1	1	3	2	1	7	3
15—44 „ ...	72	40	—	—	—	—	—	—	—	—	—	2	7	4	8	10
45—64 „ ...	81	52	—	—	—	—	—	—	—	—	—	—	14	16	2	1
65 and over ...	85	75	—	—	—	—	—	—	—	—	—	—	6	7	—	—
Age unknown ...	5	4	—	—	—	—	—	—	—	—	—	1	—	—	1	1
Total (all ages) ...	329	249	1	1	1	1	2	2	—	2	2	9	29	28	28	28
	578		2		2		4		2		11		57		56	

The table below affords a comparison with the preceding eight years:—

Disease	Number of corrected notifications									
	1954	1955	1956	1957	1958	1959	1960	1961	1962	
Scarlet Fever	1,993	1,633	1,496	1,277	1,949	2,441	1,536	911	652	
Whooping Cough	3,252	3,112	4,265	2,089	1,226	953	3,227	838	241	
Acute Poliomyelitis (paralytic)	44	244	35	78	99	12	6	34	7	
Acute Poliomyelitis (non-paralytic)	20	86	28	17	53	8	—	6	3	
Measles	5,558	29,357	3,281	28,352	6,183	24,480	4,636	29,225	11,485	
Diphtheria	4	—	—	—	2	3	—	—	1	
Dysentery	1,454	1,310	2,685	1,377	2,513	1,169	954	1,166	920	
Meningococcal Infection	41	39	71	64	48	30	23	32	20	
Acute Pneumonia (primary or influenzal)	1,144	1,121	1,098	1,324	909	1,007	530	801	578	
Smallpox	—	—	—	—	—	—	—	—	2	
Acute Encephalitis (infective)	4	2	3	8	5	1	5	1	2	
Acute Encephalitis (post-infectious)	4	4	2	5	2	1	1	6	4	
Typhoid Fever (excluding Paratyphoid)	5	5	1	—	—	4	—	2	2	
Paratyphoid Fevers...	30	25	14	3	3	7	1	11	11	
Erysipelas	307	263	186	179	173	167	136	78	57	
Food Poisoning	276	346	572	290	135	256	358	58	56	
Ophthalmia Neonatorum	17	15	13	7	9	6	5	6	3	
Puerperal Pyrexia	131	136	98	77	84	66	61	68	51	
Tuberculosis:										
Respiratory	1,084	1,033	866	802	763	627	547	550	469	
Other Forms	206	205	184	132	117	115	75	89	64	
*Malaria	9	2	2	—	1	—	—	1	1	
Anthrax	—	—	—	—	—	—	2	1	1	
†Chicken-pox	694	370	474	359	712	434	900	278	578	

*All the cases of malaria shown in the above table were believed to be contracted abroad.

†Chicken-pox is compulsorily notifiable only in certain County Districts, and the figures given do not, therefore, represent the full number of cases occurring in the Administrative County.

Vaccination and Immunisation:

The wide range of antigens and vaccines now available, some for use as a single antigen, some in combined and some in triple form, creates a somewhat complex situation and the County Council's recommended immunisation programme has proved a great help to both medical and lay personnel. The programme, which is reproduced below, is incorporated on the personal record card which is issued to parents.

Desirable Age	For Protection Against	Number of Injections
2—6 months	Diphtheria Whooping Cough Tetanus }	3 (triple vaccine)
6—10 months	Poliomyelitis	3 doses (oral vaccine)
*15—18 months	Diphtheria Whooping Cough Tetanus }	1 (triple vaccine)
18—24 months	Smallpox	—
5 years	Diphtheria/Tetanus	1 (combined vaccine)
10 years	Diphtheria/Tetanus	1 (combined vaccine)
11—13 years	Tuberculosis	B.C.G.

* Only when considered necessary by the doctor.

The only recent amendment to the programme is the introduction of the booster dose of triple vaccine at 15—18 months, but it is emphasised that this booster dose is given only when considered necessary by the doctor concerned.

The record card also provides space for recording each injection given and the date of the next appointment. The card is issued together with a transparent protective cover large enough to hold the child's National Health Service record card. It is retained by the parent but presented for endorsement to the general practitioner or clinic doctor when further injections are given. A note on the card, printed prominently in red, emphasises the importance of producing the record in cases of illness or accident. This is especially important where tetanus immunisation has been given, since it could obviate the need for administering A.T.S. (anti-tetanic serum) which is known to produce reactions, occasionally severe, in some allergic individuals. The antigen used for non-emergency routine immunisation, viz. tetanus toxoid, is, on the other hand, entirely innocuous.

Tetanus Immunisation:

The increased use of triple vaccine, which gives simultaneous protection against tetanus, whooping cough and diphtheria, means that many children now receive protection against tetanus at an early age. Triple vaccine has, however, been in use only since 1957 and many of the children now at school did not receive protection against tetanus in infancy. The general policy in the County is to give tetanus protection to these children at the same time as giving a diphtheria immunisation booster dose. This is done by using the combined diphtheria/tetanus antigen at the appropriate time, as shown in the schedule on page 49.

The total number of children who completed a primary course of protection against tetanus during 1962 was 27,501 and, of this number, 19,447 were born in the years 1961 and 1962.

A secondary, or reinforcing injection, was given to 3,213 children. The majority of the children (2,564) who received reinforcing injections were in the 6—10 years age group.

When a patient has received anti-tetanus serum at a hospital, it is now the accepted practice for the hospital authorities to give the patient a letter advising him to go either to his own general practitioner or to the local health authority for active immunisation. This is done to avoid the increased danger of anti-tetanus serum reactions on any future occasion.

Tetanus immunisation is now being offered to coal miners by the Medical Service of the North Eastern Division of the National Coal Board and the Health Committee has agreed that the vaccine required for the immunisation of coal miners in the West Riding be made available to Coal Board Medical Officers.

Scarlet Fever:

Corrected notifications again declined markedly to 652 compared with 911 in 1961, and an annual average of 1,840 in the decennium 1952—61; indeed, the total for 1962 was the lowest ever recorded. Nationally, incidence was also low at 0·33 per 1,000 population compared with the County's 0·39. The seasonal incidence, as in former years, was highest in autumn and winter. Notifications were most numerous in young children, only 18·5 per cent. being 10 years or over.

The disease, save in exceptional cases, is mild, is readily amenable to treatment, and has been almost eliminated as a cause of death.

Whooping Cough:

The fall in the number of notifications continued to the record low total of 241. These notifications are a mere 6 per cent. of the annual average recorded since 1940 when notification was introduced. Slightly more than half the notifications arose in the first quarter and only 25 in the third quarter.

Age-sex incidence closely followed the experience of post-war years; 13·3 per cent. of the cases were under 1 year, 39·4 per cent. in the 1 and under 4 years age group and 44·0 per cent. at ages 4—9 years, with a slightly higher incidence among females.

IMMUNISATION AGAINST WHOOPING COUGH:

With the increased use of triple antigen, most young children now receive protection against whooping cough at the same time as they are protected against diphtheria and tetanus. The single whooping cough vaccine is, however, still available if special circumstances make it undesirable to use the combined antigen.

During the year 21,090 children received a full course of immunisation against whooping cough and since facilities were first introduced in 1952 a total of 154,236 children have been immunised under the County scheme. The number of children protected in the 0—4 years age group is 84,273, representing 76·3 per cent. of the total population in this age group.

Of the 240 notifications of whooping cough in the 0—14 years age group, only 45 concerned children who had been immunised against this disease. One death from whooping cough was notified; this was a child under one year who had not been immunised.

Poliomyelitis:

After revision of diagnosis only ten cases of poliomyelitis were confirmed, seven of the paralytic form and three non-paralytic, the age-sex distribution of which appears on page 47. This total is second to 1960 in being the lowest recorded since the disease came into prominence in this country in 1947.

Each case was meticulously investigated and details are appended.

Cases 1 and 2 were sisters aged $5\frac{1}{2}$ and 2 years; both were non-paralytic and made uneventful recoveries.

Case 3 was a boy of 3 years. He had measles but, as he did not appear to recover fully from this illness within 4 weeks, he was referred to a consultant pædiatrician who discovered some paresis of the lower limbs and considered that it was a post-poliomyelitis paresis. At the time of writing there was slight muscle weakness in his right leg for which he was attending an orthopædic consultant's clinic.

Case 4, a four year old girl, had paralysis of moderate severity of right leg and has slight residual paralysis.

Case 5, a male of 33 years was admitted to hospital with paralysis of the right hip, right knee and foot. There was some improvement later of the ankle movement, but residually both the right hip and knee were affected.

The sixth case, a 7 year old boy, was admitted to hospital with meningism and paresis of both lower limbs, also left upper limb. A fair recovery was made and at the year end he was walking well with calipers and hoping to return to school.

Case 7 was a year old girl whose paralysis of right leg necessitated tendon transplantation. Further surgical treatment is anticipated but in April, 1963, she was walking well with a caliper.

Eight, nine and ten were associated cases. Case 8 was an 11 year old girl who took ill on the 5th July. The day before the doctor was called she was unable to walk. Her home and school contacts were checked and vaccinated against poliomyelitis using trivalent oral vaccine. She was severely paralysed, more so in the legs than in the arms, and it is probable that she will be under treatment for some months. The date of onset of case 9, a boy of 8 years, was 19th July.

He was a pupil at a Junior Boys' school and, although these premises adjoin the Junior Girls' school attended by case 8, the more likely source of contact was her brother who had played with this boy during the incubation period of his sister's illness. There was ocular and facial paralysis and some involvement of the right arm but, fortunately, he made a good recovery.

Case 10, an 8 year old boy, sat behind case 9 at school and also had contact with the family of case 8. This was a puzzling case for he had been under treatment since 18th July with a pyrexia of unknown origin. The situation was rather confused because of the treatment with antibiotics but on the date of admission to hospital, 28th July, there was no doubt about the meningeal involvement. This was mainly an encephalitis, rather than a spinal poliomyelitis, and although the boy remained ill for a few days in hospital there was no paralysis and he made a complete recovery.

Seasonally, two cases arose in the first quarter, three in the second, and five in the month of July.

Poliomyelitis virus Type 1 was isolated from 6 of the cases.

That poliomyelitis vaccine confers a measure of protection against the paralytic form of the disease is clearly underlined; case 4 had received one injection only of Salk vaccine seven months prior to onset, the remainder were unvaccinated as were the non-paralytic cases.

VACCINATION AGAINST POLIOMYELITIS:

In February the Minister of Health made available to local health authorities the live attenuated poliovirus vaccine prepared from strains developed by Dr. A. B. Sabin. The great advantage of this new vaccine is that it can be given by mouth and it has now become commonly known as "oral vaccine". Full details of the distribution and storage arrangements for this vaccine were given in Ministry of Health Circular 3/62, wherein it was stated that the vaccine was available for use in the routine vaccination of persons eligible under the approved arrangements, i.e., those over six months and under 40 years of age and certain others at special risk. General practitioners were given the opportunity to take as full a part in the arrangements for routine vaccination with oral vaccine as they had done in the past with 'Salk' vaccine.

The oral vaccine gives protection against all three types of poliomyelitis virus. The recommended course consists of three doses given at intervals of four to eight weeks. Young infants are given the vaccine with syrup but older children and adults receive it on a lump of sugar. In announcing the availability of oral vaccine the Minister said that he had been advised by the Joint Committee on Poliomyelitis Vaccine that the new vaccine was safe, reliable and effective.

The first batches of oral vaccine had a life of 12 months when stored in "deep freeze" and a life of one month in an ordinary domestic refrigerator; consequently a "deep freeze" unit was installed in the County Health Department.

In July a more stabilised type of oral vaccine became available. This new vaccine can retain its potency in an un-frozen state at a temperature not exceeding 10°C for a period of six months, and can be kept at room temperature for a cumulative period of not more than 14 days, thus greatly facilitating the arrangements for storage and distribution.

Although 'Salk' vaccine continues to be available for any doctor who particularly wishes to use this type of poliomyelitis vaccine, the demand for 'Salk' vaccine is now so slight that for all practical purposes it has been superseded by the oral vaccine.

The number of doses of oral vaccine administered in 1962 totalled 212,291 and 45,851 injections of 'Salk' vaccine were also given. Most of the 'Salk' vaccine was administered in the two months before oral vaccine became available.

The total number of persons protected against poliomyelitis in the County, taking into account both 'Salk' and oral vaccine, at 31st December, 1962, is as follows:—

<i>Age Group</i>	<i>Total Protected</i>	<i>Percentage Protected</i>
Under 1 year	2,769	21·3
1— 2 years	12,591	46·6
2—20 years	380,363	85·3
20—29 years	111,605	53·9
29—42 years	74,085	23·3
Total all groups	581,413	57·5

Measles:

The incidence followed its usual biennial rhythm, the number of cases showing a sharp decline compared with that of 1961, an epidemic year. Notifications remained low during the first three quarters of the year, at no time exceeding 160 per week; from the end of September incidence increased to around 1,000 cases per week in December and continued until mid-January, 1963.

Measles is ubiquitous and few children escape far beyond their entrance to school without contracting the disease; indeed, 51 per cent. of the notifications related to children under 5 years and 45 per cent. in the 5—9 years age group.

Although the incidence has not materially changed, mortality from this disease has steadily fallen (see table below), but this should not be assumed to be due to any decrease in the virulence of the measles virus. The complications of measles are usually due to secondary infection by other micro-organisms. The use of antibiotics for the treatment of complications and the nursing of patients in more hygienic and less overcrowded rooms are the more likely causes of the fall in mortality.

Year	Number of notifications	Number of deaths	Fatality ratio (deaths per 100 notifications)	Year	Number of notifications	Number of deaths	Fatality ratio (deaths per 100 notifications)
1949	16,489	18	0·11	1956	3,281	1	0·03
1950	15,763	9	0·06	1957	28,352	5	0·02
1951	25,194	17	0·07	1958	6,183	1	0·02
1952	13,938	7	0·05	1959	24,480	6	0·02
1953	19,853	9	0·05	1960	4,636	—	—
1954	5,558	3	0·05	1961	29,225	8	0·03
1955	29,357	4	0·01	1962	11,485	3	0·03

Diphtheria:

Following two years of freedom from the disease a setback was recorded, a fatal case of an unimmunised five year old boy. Onset of illness with a sore throat, malaise, vomiting and difficulty in breathing, was on 13th March and on the 16th the diagnosis of diphtheria was made and the child admitted to I.D. Hospital, a throat swab revealing the presence of *C. diphtheriae* mitis. He was transferred later that day to a children's hospital where a tracheotomy was performed. The following day he was transferred to an I.D. Hospital and when seen by the consultant his condition appeared satisfactory. Subsequently, his condition deteriorated and he died on 18th March. The cause of death was obstruction below the tracheotomy probably due to membrane.

Contacts, including three other immunised children in the family, were given toxoid and unimmunised close contacts additionally were given anti-diphtheritic serum.

Investigations were carried out with promptitude and assiduity but in spite of the examination of over 500 nose and throat swabs from school and home contacts the source of the infection remained untraced.

It is interesting to note that the boy had not been immunised but the three other siblings who had did not contract the disease. This underlines the need to secure and maintain the immunisation state at the highest possible level.

DIPHTHERIA IMMUNISATION:

The number of children who received immunisation during 1962, together with figures for previous years, are shown in the following table:—

Year	Number of children who completed a full course of immunisation			Number of children who were given a reinforcing injection
	Under 5	5—14	Total	
1948	20,958	6,220	27,178	19,274
1949	20,728	7,162	27,890	18,071
1950	14,836	3,961	18,797	13,929
1951	16,606	5,567	22,173	17,092
1952	15,798	5,298	21,096	23,390
1953	13,768	4,893	18,661	22,614
1954	15,207	5,013	20,320	22,515
1955	13,566	4,516	18,082	18,663
1956	14,874	4,367	19,241	18,130
1957	15,032	4,803	19,835	15,034
1958	17,273	2,368	19,641	9,541
1959	20,162	2,892	23,054	14,852
1960	23,351	5,363	28,714	21,653
1961	23,982	8,108	32,090	20,557
1962	21,086	2,908	23,994	9,730

There was a slight reduction in the number of children who completed a primary course of immunisation against diphtheria and a considerable fall in the number of children who received reinforcing doses. This was partially due to a fall in the number of immunisations done by general practitioners who were under severe pressure owing to the high sickness rate in the early part of the year. Another factor was the smallpox outbreak and the diversion of medical staff to deal with the large numbers who were vaccinated. It is, however, very encouraging to note that a good proportion of infants are still receiving protection against diphtheria before their first birthday. The following table shows the progress made in this group during recent years:—

Children immunised before first birthday
Percentage of
population
in age group

<i>Year</i>	<i>Number Immunised</i>	
1955	1,781	7.5
1956	2,623	10.2
1957	9,189	35.9
1958	11,269	42.2
1959	13,732	51.2
1960	17,511	65.8
1961	17,532	62.8
1962	17,374	61.2

The ultimate aim is to immunise at least 75 per cent. of children before they attain their first birthday.

The following table gives details of the immunisation state at the end of the year of the child population 0—14 years inclusive, compared with previous years:—

Number Immunised

Year	Under 5	Percentage of population under 5	5—14	Percentage of population 5—14	Total under 15	Percentage of population under 15
1948	59,795	44.1	139,194	65.0	198,989	56.9
1949	64,811	46.7	143,966	65.8	208,777	58.4
1950	66,484	47.9	150,179	67.1	216,663	59.7
1951	66,077	47.4	150,177	70.1	216,254	61.5
1952	60,885	46.4	177,875	74.8	238,760	64.7
1953	54,304	42.9	198,151	81.4	252,455	68.2
1954	55,990	45.2	217,052	87.5	273,042	73.4
1955	53,180	43.6	224,126	88.3	277,306	73.8
1956	53,147	43.6	233,120	90.2	286,267	75.2
1957	54,572	44.1	231,100	89.2	285,672	74.6
1958	58,457	46.4	226,593	87.3	285,050	73.9
1959	64,878	50.5	219,178	85.1	284,056	73.6
1960	73,078	55.4	226,566	88.5	299,644	77.3
1961	83,024	61.7	234,805	92.1	318,829	81.9
1962	86,851	63.1	220,347	88.4	307,198	79.4

Dysentery:

The number of corrected notifications decreased slightly from 1,166 in 1961, to 920, the lowest annual total recorded since 1953. Contrary to the customary seasonal variation, notifications were more numerous in the second and third quarters as is indicated below.

		Male	Female	Total	Percentage of annual total
First quarter	...	101	103	204	22·2
Second quarter	...	126	128	254	27·6
Third quarter	...	110	133	243	26·4
Fourth quarter	...	109	110	219	23·8

Notifications by sex and age groups during the past six years were as follows:—

	Males				Females				Persons			
	All ages	0—	5—	10+	All ages	0—	5—	10+	All ages	0—	5—	10+
1957	733	245	215	273	644	209	142	293	1,377	454	357	566
1958	1,236	380	421	435	1,277	361	387	529	2,513	741	808	964
1959	597	191	168	238	572	173	146	253	1,169	364	314	491
1960	478	181	105	192	476	155	97	224	954	336	202	416
1961	592	206	159	227	574	177	136	261	1,166	383	295	488
1962	446	158	142	146	474	152	142	180	920	310	284	326

The table shows some decline of incidence over the last five years, probably due to improvement in the general level of hygiene especially in relation to the cleanliness of hands and food. There can be little doubt that the simplest and most effective single method of preventing the spread of this disease is the thorough washing of hands after every visit to the lavatory.

Meningococcal Infection:

Meningococcal infection as distinct from “cerebro-spinal” fever has been notifiable from 1950, since when notifications have fluctuated but have tended to pursue a downward trend. The total of 20 is the lowest yet recorded under either classification.

The number of corrected notifications and deaths since 1950 are given below:—

Year	Number of notifications	Number of deaths	Fatality ratio (Deaths per 100 notifications)
1950	55	14	25·5
1951	57	13	22·8
1952	50	6	12·0
1953	37	12	32·4
1954	41	15	36·6
1955	39	10	25·6
1956	71	9	12·7
1957	64	13	20·3
1958	48	7	14·6
1959	30	6	20·0
1960	23	4	17·4
1961	32	5	15·6
1962	20	4	20·0

Four of the notifications were of infants under 1 year and five in the 1—4 years age group. All the cases appear to have been sporadic with no apparent connection.

The infection is one of the residual problems in the elimination and control of infectious disease for, although with modern treatment the fatality rate has reduced appreciably, a high proportion of the deaths occurs in infants where the making of a correct early diagnosis is often difficult.

Smallpox:

Two imported cases in December, 1961, elsewhere in the country, alerted Medical Officers of Health and heralded an outbreak involving 14 cases, two of whom were West Riding residents and two originally diagnosed in the Wharfedale Children's Hospital at Ilkley.

In retrospect, the source of the outbreak was a 9 year old Pakistani girl who arrived in this country by air. She fell ill and was admitted to the Bradford Children's Hospital with malaria. She subsequently died but at that time there was nothing to suggest that the death was due to smallpox. She had, however, infected six other children and a nurse in the same ward of the hospital, a visitor and one of the hospital cooks. The pathologist who performed the post-mortem on the first case also acquired the infection and subsequently died. The total number of cases in the first generation was 10, of whom 5 died.

One of the children developed smallpox after transfer to Wharfedale Children's hospital, where the infection was acquired by one other child. The visitor to Bradford Children's Hospital was admitted, before the diagnosis was established, to St. Luke's General Hospital where he infected two other patients. The total number of cases in the second generation was 3, of whom 1 died, though this was not assigned to smallpox.

An account of the outbreak and the issues involved were contained in an article by Dr. Lyons and myself which appeared in "The Medical Officer" published on 8th June, 1962. The article is reproduced in full below:—

ALTHOUGH the outbreak of smallpox in Yorkshire in January, 1962, was largely confined to hospitals in Bradford,* it had considerable repercussions in the West Riding County Administrative Area. Two of the 14 patients were West Riding residents and two were first diagnosed at the Wharfedale Children's Hospital within the county area. Furthermore, the contacts of these and of some of the Bradford patients resided in the county area. Over 250 individual West Riding contacts were under surveillance, involving no less than 10 divisional areas. The events during and following this outbreak brought to notice several matters of importance to medical officers of health in general and county medical officers in particular.

ROLE OF THE COUNTY MEDICAL OFFICER

The role of a county medical officer in the control of an outbreak of smallpox has never been clearly defined. The major responsibility for controlling infectious diseases rests generally with the district medical officer of health but, rather strangely, his responsibility as a vaccinator is restricted by the Public Health (Smallpox Prevention) Regulations, 1917, to the vaccination of "any person who has come in contact with the infection." There is no authorization for the vaccination of the general public, and the district MOH also lacks statutory authority to vaccinate the families of contacts. In other words, he cannot—as district MOH—undertake vaccination in accordance with the "ring" technique the essence of which is the vaccination—before exposure to infection—of the ring of "secondary" contacts, i.e., members of the household and others likely to be in contact with the primary (direct) contact at the end of the latter's presumptive incubation period (see Appendix C). The responsibility for vaccination of other than direct contacts appears to rest with the local health authority and is governed by the approved proposals under Section 26 of the National Health Service Act. The proposals of the West Riding CC under this Section

*Smallpox in Bradford, 1962; Douglas, J., and Edgar, W. (1962): *Brit. Med. Journal*, i, 612.

provide for arrangements for the vaccination or re-vaccination of members of the general public during an outbreak "if advised." It is presumed that, as this wording was part of the County Council's scheme, the advice referred to therein would be that of the county medical officer. It is evident then that there is a sharing of responsibility in the control of a smallpox outbreak between the district MOsH and the CMOH. Whatever the legal position, however, it is imperative that, in an emergency of this kind, the CMOH and the district MOsH must act with the maximum degree of co-ordination. This is facilitated in the West Riding by the fact that every district MOH is also a divisional medical officer of the County Council, responsible in his area for the day-to-day administration of the County Council's health services other than the ambulance and dental services.

Vaccination under Section 26 of the National Health Service Act probably represents the full statutory responsibility of the CMOH in relation to a smallpox outbreak in or near his area, but recent events have shown that a CMOH can go beyond these statutory limits in order to assist hard-pressed district MOsH. Assistance was, in fact, given by the central office at Wakefield in the following ways:—

(a) Medical, nursing and clerical staff throughout the county area were given the opportunity of volunteering to give assistance in any division where the need arose. There was a ready response from the staff and arrangements were made for the volunteers to be vaccinated (or revaccinated) forthwith. Most of the medical and nursing staff had already been revaccinated, as advice to this effect had been circularized to all divisions as soon as it was known that smallpox had been imported into the country, i.e., several weeks before the onset of the Bradford outbreak. Clerical staff volunteers included a number from other departments in County Hall and these were vaccinated in the central office. District MOsH and their staffs worked long and arduously in the surveillance of contacts and in dealing with the problems and inquiries of innumerable members of the public. Their own staff of public health inspectors and health visitors proved to be inadequate in most divisional areas bordering on Bradford, and the assistance offered by the CMOH was gladly accepted. It should be added that we were not parochial in our emergency distribution of county staff and, indeed, in the first day or two of the outbreak we gave more assistance to the County Borough of Bradford than to our own area.

(b) It was clear at a very early stage that the Bradford MOH would have considerable difficulty in disseminating information with regard to West Riding contacts to the appropriate district MOH. It was vital that this information should reach the district MOsH in as few hours as possible in order that the contacts could have the benefit of early vaccination. There was also a danger that the persons delegated to perform these tasks might not always be aware of the geographical locality of some of the West Riding towns and villages, and considerable delay would be involved if the information were sent to the wrong district MOH. We, therefore, offered to act as a "clearing house." Information with regard to all West Riding contacts was collected personally at Bradford by the CMOH and then disseminated by telephone to the appropriate district MOH. Confirmation in writing followed. This service was generally appreciated by the MOsH concerned.

(c) In any outbreak of smallpox it is essential that MOsH of neighbouring authorities are aware of what is happening at the centre of the outbreak. The MOH of the town or district chiefly affected is usually too preoccupied to give other than the most vital information, i.e., with regard to contacts, but more detailed information of the progress of the outbreak is required by other MOsH, if only to deal with inquiries or rumours or to enable them to assess or reassess their own line of action. This need is recognized by the Ministry of Health, who provide information of this general nature to all MOsH. Our experience has been, however, that these Ministerial circulars are too infrequent. It was decided, therefore, that—as far as our own divisional MOs were concerned—we should provide a daily "news" service, collecting information from all the areas involved, including Bradford. The Bradford MOH was most helpful and co-operative. These daily bulletins proved to be extremely popular and we know of at least one county borough MOH who asked a neighbouring colleague (a divisional MO) if copies could be spared. It is probable that some county borough health departments felt themselves starved of important information, and consideration needs to be given to the provision of daily, up-to-date information to all neighbouring MOsH in an emergency of this kind. Examples of the daily bulletin are appended (see A and B). Altogether, 14 daily bulletins were issued covering the most acute phase of the outbreak.

(d) The provision of clinical thermometers to enable one thermometer to be kept in each home under surveillance.

(e) The CMOH and his deputy made themselves available in an advisory capacity with regard to the administrative aspects of control. Care was taken, of course, not to "push" advice too enthusiastically but all the district MOsH chiefly affected by the outbreak did,

in fact, take advantage of the offer. If the advice did no more than boost morale, it was, nevertheless, of some value as some medical officers were being pressed very hard to provide facilities for mass vaccination including sessions at factories and schools.

More detailed assistance was given in the drawing up of forms for the documentation of contact surveillance (see Appendix C).

A good deal of the surveillance has perforce to be delegated to doctors and nurses who may know little of the circumstances of the persons they visit and have even less idea of precisely what their function is at different stages of the surveillance. The form in Appendix C includes the definition of the terms "primary contact" and "secondary contact" and provides for the recording of all the important facts relating to the time and circumstances of the contact. Specific instructions are given on the form in relation to the vital details of surveillance on and after the tenth day of the quarantine period. The space provided for the recording of vaccination and revaccination helps to remind the visiting doctor or health visitor of the only safe criterion of success of vaccination, namely a vesicular response, and provides the information upon which a decision can be made as to whether further attempts at vaccination are required. This detailed documentation is particularly necessary, if, as so often happens, contacts are visited by different personnel on different days. It also reduces to a minimum the precious time required for the briefing of doctors and health visitors by the MOH.

THE ISSUE OF MASS VACCINATION

The majority of medical officers of health in the West Riding geographical area neither advocated nor practised mass vaccination in the recent outbreak. A few did not advocate it but practised it, and one or two, who both advocated and practised it, were in areas not directly affected! This lack of uniform policy confused both the public and general practitioners, especially the latter, most of whom have very little knowledge of up-to-date developments in smallpox epidemiology and simply could not understand why mass vaccination was being withheld in some areas. The unbalanced publicity given in the Press and on television to mass vaccination and the "shortage" of lymph tended to confirm the impression shared by the public and general practitioners that mass vaccination was the normal method of dealing with outbreaks.

The views of the majority of MOsH were not given sufficient prominence in the Press, nor was the statement of the Chief Medical Officer of the Ministry of Health that mass vaccination should be discouraged.

There is obviously a need in outbreaks of this kind for a reassuring and firm lead to be given to the public and to the medical profession at the earliest possible moment and this should preferably be given as a result of a meeting of medical officers of health as was done in the Midlands. Representatives of the Hospital Board administrative staff and of the Local Medical Committee should also be invited. Such a meeting would make it difficult and embarrassing for the dissenting minority subsequently to air its outworn ideas. It is, of course, realized that the MOH chiefly involved in an outbreak has little time to call a meeting in the first day or two, but the difficulty is one that should be overcome, especially since it would have the effect of helping the particular MOH in resisting the demands of the public, his committee and the general practitioners. After such a meeting, a statement should be issued to the Press and facilities offered for a press conference. Requests to appear on television should not be refused as this could be an excellent opportunity for giving the views of the MOH.

One further point: mass vaccination is not only the result of panic; it also generates panic, resulting in an ever-widening geographical circle in which more and more vaccination is demanded.

The disadvantages of mass vaccination are still not fully recognised even by our own colleagues, and we hope we may be forgiven for recounting them as follows:—

(a) Mass vaccination diverts public health staff from the major task of ascertainment and surveillance of contacts.

(b) Mass vaccination causes widespread illness, absenteeism and dislocation. The National Insurance figures of first claims were comparable in some areas with the statistics one would expect as a result of a moderate outbreak of influenza.

(c) The incidence of *serious* complications, including deaths, cannot be ignored when dealing with hundreds of thousands or millions of people. Statistics collected from Annual Reports of the Chief Medical Officer of the Ministry of Health show that, in the 11 years 1950-60 inclusive, there were 33 deaths in England and Wales arising from the primary

vaccination against smallpox of 4,000,000 persons, i.e., an overall mortality of about eight per million primary vaccinations. The use of this technique, therefore, involves the risk of causing more deaths from vaccination than would be caused by a small outbreak controlled by "ring" vaccination. It should be especially noted that most of the deaths occur in the first and second generations of any outbreak and neither "ring" *nor* mass vaccination is sufficiently early to prevent these deaths. Subsequent deaths are almost certain to be exceeded in number by deaths from vaccination, if mass vaccination is persisted in. The general medical principle of not employing a method of treatment which has more risks than the disease needs to be applied to the control of smallpox.

(d) There is no reason to doubt the efficacy of the "ring" vaccination technique. Even if a health department fails to ascertain any of the contacts, the subsequent spread of the disease is more likely to be checked if an unascertained contact remains unvaccinated than if he is vaccinated in the early stage of the incubation period at a public session. Incidentally, the risk of failure to ascertain a contact would appear to be very small indeed. Our recent experience has shown that, where smallpox is concerned, the public is more than co-operative and medical officers have been bombarded with appeals from hundreds of people who have claimed to be contacts. The public has, in fact, filled very adequately any gaps there may otherwise have been in the routine investigations of medical officers of health and their staff. It is of special interest that none of the recent cases of smallpox in Bradford and the West Riding occurred in other than ascertained contacts. We are also given to understand that, with the exception of the sources of the new outbreaks, the same applies to the South Wales epidemic.

To sum up, "Mass vaccination has the advantage of not requiring the MOH to possess either a knowledge of epidemiology or more than a modicum of intelligence. Its organization can be safely delegated to a junior clerk. Even an 'administrator with medical knowledge' would probably be superfluous! Mass vaccination can be compared with killing houseflies with a shotgun. The alternative method is 'ring' vaccination . . . This method requires specialized knowledge, judgment, discrimination and finesse. It elevates the MOH to his proper role of consultant epidemiologist and gives him the opportunity so rarely available of blending his medical, health visitor, sanitary and clerical staff into a single public health team under his unquestioned leadership." (Lyons, J., 1956.)*

CONTROL OF THE DISTRIBUTION OF VACCINE LYMPH

The Yorkshire outbreak of smallpox was almost unique in this country in that it gave rise to a tremendous demand for vaccination, not only locally but far afield. The demand was, for example, much heavier and widespread than in the Todmorden outbreak†. This partly arose out of undesirable publicity, but, in the main, was a result—however illogical—of the association of this outbreak with colour prejudice. Emotion was far more in evidence than reason and even within the medical profession there were understandable signs of tension. The resultant demand for vaccine lymph was unprecedented and unfortunately coincided with a breakdown at one of the largest places of manufacture. Within a few days the public health laboratories found it necessary to ration very strictly the distribution of lymph. Most unfortunately the control was exercised in different ways at different public health laboratories within the area and this undoubtedly caused widespread concern, frustration and irritation. So far as the Wakefield laboratory was concerned, the Director (Dr. Little) voluntarily put much of this control of distribution into our hands and absolute priority was given only for the "ring" vaccination of contacts and the vaccination of groups at "special risk," e.g., general practitioners and their families, public health and ambulance staff, etc. There was no similar arrangement with other public health laboratories serving parts of the West Riding county area. What one did not realize at the time, however, was that the issue of lymph for this purpose represented the discharge of a function under Section 26 of the National Health Service Act, and it would seem that the MOH of a Local Health Authority has a statutory right to control the distribution of lymph used for the purpose of Section 26, i.e., in accordance with that LHA's approved scheme of vaccination. Thus, if the approved scheme provides for the vaccination of the general public during an outbreak, it follows that the MOH can legitimately control the lymph to be used for that purpose.

The following extract from a Ministry of Health circular dated 14th December, 1949, appears to confirm this position:—

*The Management of an Outbreak of Smallpox—Administrative and Epidemiological Aspects (Lyons, J.): *Public Health* 5, Vol. LXIX, Feb., 1956.

†Smallpox in the Industrial Pennines, 1953, Dixon, C. W., and Lyons, J. (1953): *THE MEDICAL OFFICER*, 90, 293, 307.

“ *Supply of Vaccines, etc.*—Under Section 26(4) the Minister intends to supply, free of charge, to Local Health Authorities and medical practitioners providing services under Section 26, the lymph required for vaccination against smallpox and the prophylactic required for immunization against diphtheria.” The wording of Section 26(4) is as follows:—

“ The Minister may, either directly or by entering into arrangements with such persons as he thinks fit, supply free of charge to local health authorities and medical practitioners providing services under this section, vaccines, sera or other preparations for vaccinating or immunizing persons against any disease.”

PAYMENT FOR VACCINATION RECORDS

As is generally known, a large number of general practitioners did little to resist demands for vaccination by the general public; a minority actually encouraged it by the display of notices outside their surgeries and by other means. This partly arose from a lack of understanding of modern epidemiological techniques and of the potential dangers and hazards of smallpox vaccination. To be realistic, one must add the suspicion that among a few GPs the pecuniary motive was not entirely absent. We were soon faced with a situation wherein the County Council would be paying a very large sum for a service which it did not require and which it had endeavoured to discourage. We had, of course, to honour our existing obligations, but the Health Committee made it clear that it did not wish this situation to continue or to occur again in the future. It was, therefore, resolved by the Health Committee that records would no longer be required in respect of the vaccination against smallpox of persons over the age of 16 years. This action had already been taken by Leeds County Borough, and the example was subsequently followed by York County Borough. Some other authorities are, it is understood, reviewing the position. We appreciated that this decision would not be popular with general practitioners but felt, nevertheless, that it was time to drive home the undesirability of indiscriminate smallpox vaccination. The general practitioners were accordingly circularized on the position, the reasons therefor being given in detail. The decision was subsequently discussed at a meeting of the Local Medical Committee, and it was agreed that any queries or complaints from members or other general practitioners should be considered by the Standing Sub-Committee on Co-operation. The latter is an informal committee, formed several years ago to deal with matters of mutual interest to general practitioners and the local health authority. The Committee is entirely medical and consists of representatives of the Local Medical Committee and medical officers of the West Riding Health Department. There was a number of interesting points raised by the general practitioners in the discussion, and a few are worthy of special mention, as follows:—

The Right of a Practitioner to Refuse a Request for Vaccination

(a) Many general practitioners appear to have assumed that their terms of service were such that they could not refuse any request for vaccination. Our own opinion is that, in dealing with a request from a patient, the practitioner must decide whether the risk of serious complication from vaccination is greater or less than the risk of the patient acquiring smallpox. The practitioner would be guided in making his decision by the age and condition of the patient and the prevailing circumstances. If a patient is not a direct or secondary contact of infection, he could well decide against vaccination. Having made such a decision, it would then be a breach of ethics if he complied with the request of the patient ! One of the general practitioners on the Standing Sub-Committee felt that the GPs could be in a difficult legal position if a patient, who had been refused vaccination, subsequently developed smallpox. We replied that this would be no more difficult than the situation that would arise if a patient died as a result of an unnecessary vaccination. There could surely be no legal hazard in either event if the doctor arrived at his decision conscientiously and without negligence. There is certainly no precedent in the National Health Service for decisions on the need for any item of service to be made by the patient.

(b) A number of general practitioners felt that, in refusing to pay for the records after 12th February, 1962, we were, in effect asking doctors to do work without payment. It had to be pointed out that, if records are not required, then GPs will not have the work of completing them ! There is no doubt that a number of GPs still confuse payment for records with payment for the performance of vaccination. One complaining doctor said that our decision would result in the public suffering. It is difficult to see how a decision not to require records and certain statistics, because they have proved valueless, could result in “ suffering.”

(c) The right of the West Riding CC to cease payment was disputed by some. It was submitted that this was a breach of the agreement with the British Medical Association made in 1949, and should not, in any case, be done without the consent of the Ministry.

We have gone into this matter very carefully and have, of course, been guided by the advice of the Clerk of the County Council. It is clear from a study of the relevant documents that the agreement with the BMA was in relation to the fees to be paid to general practitioners taking part in LHA's arrangements for vaccination *under Section 26* of the National Health Service Act. Our own scheme did not make specific reference under Section 26 to payment for adult vaccination, and such payment was only introduced in 1953 on the recommendation of the Ministry of Health. Had our scheme been formally amended at that time, we should have been obliged to withdraw the amendment, with the consent of the Ministry of Health before putting into practice our recent decision regarding non-payment.

(d) Some doctors wanted to know why we had chosen the age of 16 as the upper limit for payment. In reply, we explained that we had a special interest in knowing the vaccinal state of persons covered by our school health service, and, furthermore, this age limit would encourage the re-vaccination in childhood of those who had been vaccinated in infancy.

(e) One or two doctors had misunderstood the reference in the explanatory circular to the large number of eruptions and reactions resulting from mass vaccination. It was explained that we were not so much concerned by the increased work caused by vaccinal reactions as by the possibility of confusing an early modified smallpox with a vaccinal reaction, thereby missing cases.

(f) One member of the Standing Sub-Committee said that there would have been less trouble and difficulty if the supply of vaccine had been solely under the control of the local authority, since a good deal of the confusion and ill-feeling within the profession had arisen out of the haphazard distribution of vaccine lymph, including its sale in pharmacists' shops.

(g) One doctor said that general practitioners should have been informed of those of their patients who were ascertained contacts. We agreed that it would be desirable for MOsH to provide this information, but we hoped it would be appreciated that, in any emergency of this kind, health department staffs are more than fully extended and ordinary courtesies may perforce be neglected. We had reason to believe that, in spite of the difficulties, most of the district MOsH in the areas affected did, in fact, keep general practitioners remarkably well informed; the remainder did their best under very difficult conditions.

The discussion of the Standing Sub-Committee undoubtedly cleared the air and the recorded Minutes, later approved without comment by the Local Medical Committee, included the statement, "the general practitioners present expressed satisfaction in general with the statements and explanation of the County Medical Officer." It could be that the factor which carried the greatest weight in determining their change of attitude was the statement from a British Medical Association source that the payments made to general practitioners following the recent outbreak will affect the Pool, possibly even to the extent of cancelling any final settlement. This was another way of saying that general practitioners *en masse* received no extra remuneration whatsoever for records of vaccination irrespective of the attitudes of different local health authorities.

INFORMATION TO THE PUBLIC REGARDING PATIENTS

As most of the patients in the recent outbreak were in hospitals, the Hospital Board set up a Press section to deal with the many inquiries with regard to hospital precautions and patients. This arrangement relieved some of the pressure on health departments as well as individual hospitals, and to that extent was greatly appreciated. There were, however, a few occasions when information with regard to individual patients was given without the fullest consideration of the effects locally, e.g., giving the town of residence of a child who acquired infection when in hospital. This information was reported by the Press in such a way as to indicate that there was infection in that particular town. In one instance the Hospital Board put out information of the transfer of a child from a long-stay hospital to the smallpox hospital without ascertaining that the parents had been given prior information. The child's name was given to the Press, again without parental consent. There was also some cautionary slowness in giving clearance to suspected cases, there being failure to recognize fully that this prolonged the considerable dislocation, hardship and heavy work involved locally in the surveillance of contacts. In one instance, a local MOH found it expedient to inform the Press himself that a particular patient was not a case of smallpox. He did this on perfectly good grounds, having spoken to the consultant, but the Hospital Board officials were perhaps a little overcautious in wanting to wait another day or two.

It should be emphasized, however, that these instances of difficulty were isolated; co-operation between the Hospital Board and the many local authorities involved was, on the whole, excellent.

REQUIREMENTS FOR VACCINATION

(a) *For the Purpose of International Vaccination Certificates*

The question has arisen as to whether a local health authority has any statutory or moral obligation to perform vaccination for the purpose of international certificates.

It would seem that vaccination in these circumstances does not come within Section 26, but it may be argued that there is a moral obligation on the part of the LHA since the vaccination is being performed for a public health purpose. On the other hand, the requirements of certain continental countries have gone beyond what is indicated in the International Regulations, e.g., vaccination should only be required for people who have been in local infected areas, that is—an area of a sanitary district in which there has been a confirmed case of smallpox. In practice, France and possibly other countries have required vaccination from all travellers from Great Britain.

(b) *Vaccination Requirements from Other Sources*

Other examples of unreasonable requests for vaccination have occurred within this country and, among the most guilty, have been our colleagues in the public health service. There was a tendency to regard every person in the geographical West Riding as potentially infectious. Children returning to residential schools and students returning to universities outside Yorkshire were required to be vaccinated before returning. It does not seem to have occurred to the authorities concerned that, unless the vaccination were performed approximately two weeks before the return of the student, there could be no guarantee that infection was not being introduced. Indeed, the effect of the vaccination might be to mask the infection in a person who was in the early stages of the incubation period.

USE OF COUNTY AMBULANCES FOR CONVEYANCE OF SMALLPOX PATIENTS

Since the 1953 outbreak, there has been an informal arrangement in the Leeds Region for the use of the West Riding CC ambulances for the conveyance of all smallpox patients, irrespective of the area of residence. This arrangement is economical, reduces the potential risk to ambulance staff and also reduces the number of ambulance staff under surveillance.

THE ROLE OF INFANT VACCINATION IN THE CONTROL OF SMALLPOX

An opportunity now presents itself for reviewing our present policy on the routine vaccination against smallpox of infants. One frequently sees the statement made by doctors who should know better that, if only mothers had agreed to have their children vaccinated, these outbreaks would not have occurred. This, is, of course, sheer nonsense. As Prof. C. W. Dixon has expressed very clearly in his new book “Smallpox,”* infant vaccination has remarkably little effect on herd immunity. To quote, “even if 100 per cent. of the infants were vaccinated, the herd immunity in England and Wales in the immediate future would not be 10 per cent.”

Dixon also states that the location of outbreaks of variola major over the last 50 years has not been related to the number of infants vaccinated in different areas, and he quotes a Ministry of Health report of 1931 to the effect that the distribution of variola minor in England and Wales has certainly not been determined by the local incidence of infantile vaccination. The Ministry of Health has no doubt been fully aware of the very small contribution made by infant vaccination to the protection of the community as a whole and the tendency has been in recent years to justify its continuance by reference to the supposedly lesser risk of serious complication from vaccination in infancy. This view that vaccination is safer in children under the age of one year than at any other time has been strongly held since the 1920s, but the statistics of deaths from vaccination over the last 10 to 15 years hardly confirm this impression. This department has collated statistics from the Annual Reports of the Chief Medical Officer of the Ministry of Health for the years 1950-60 inclusive and we have tabled in Appendix D a summary of the reported complications of primary vaccination against smallpox over this period. This would seem to indicate that, as far as mortality from smallpox vaccination is concerned, the period of maximum risk is in infancy ! One appreciates that these statistics are not based in all cases on deaths confirmed as due to vaccination by post-mortem or virological examination. Nevertheless, each reported death was presumably based on a death certificate and one would not expect practitioners to hasten to ascribe a death to vaccination if there were serious doubt about the diagnosis. It is, indeed, possible that the incidence of mortality in children under the age of one year has been underrated by the statistics. The diagnosis of encephalitis in particular is notoriously difficult in young infants. Furthermore, this diagnosis is more likely to have been missed in the 1920s when infant death was much more common and when fewer of the deaths were investigated. This could explain the difference between the statistics of the last decade and those of the 1920s.

*“Smallpox,” C. W. Dixon; J. & A. Churchill, London, 1962.

One foresees the difficulty of trying to explain to a not very well-informed public that the routine vaccination of infants against smallpox should be discontinued. Nevertheless, we are faced with the possibility that our present scheme of infant vaccination is causing more deaths than it is preventing. Our West Riding immunization schedule includes the recommendation to vaccinate at the age of 18 months to two years. This seems to be a reasonable but not entirely convincing compromise. We should also remind ourselves that one of the reasons for occasional failure to control smallpox outbreaks in their early stages is the failure to diagnose the disease in a patient partly immune due to vaccination in infancy. The introduction of a safer vaccine—surely not beyond the wit of our research scientists and virologists—would help to solve these problems. In the meantime, we should recognize that the safest method of control in this country is the tightening of international precautionary measures, supplemented by the application of the “ring” vaccination technique in those relatively rare instances where a case slips through the defences. An important second line of defence is, of course, the vaccination and regular revaccination of all persons who are at greater risk than the general public, and we would include in these groups all doctors, nurses, health department staffs, ambulance staffs and possibly also some persons working at airports and seaports. The first case in any smallpox outbreak is rarely diagnosed, and doctors and nurses and others in these priority groups could be exposed to infection without realizing it. The families of these special risk groups should also be regularly vaccinated as experience in both 1953 and 1962 has shown that vaccination *after* contact with infection, even within the first 24 hours, does not give adequate protection against clinical infection.

CONCLUSIONS

The control of smallpox in a County area requires maximum co-operation between district MOsH and the CMOH.

The County Health Department can act effectively as an information centre and as a clearing house for the transfer of data on contacts. The CMOH can mobilize and deploy his staff so as to provide assistance in any part of the geographical county. He also has a potential role as a consultant or adviser on the administrative aspects of smallpox control.

Experience of the outbreaks of 1953 and 1962 points to the need for a re-evaluation of vaccination policy and smallpox control with special reference to:—

The hazards of mass vaccination.

The practicability of the “ring” vaccination technique.

The right of the medical practitioner to refuse a patient's request for vaccination.

The doubtful value of individual records of smallpox vaccination.

The desirability of a uniform policy among LHAs with regard to the requirement of records of vaccination and the payment for same.

Lack of adequate control in the distribution of vaccine lymph.

The risks involved in routine infant vaccination and its inability to produce effective herd immunity.

The desirability of using a minimum number of ambulances for smallpox cases by agreement between the LHAs concerned.

Unreasonable and pointless requests for vaccination from official sources.

The need for presenting the public and the rest of the medical profession with an agreed firm policy of action at the earliest possible stage of an outbreak.

ACKNOWLEDGEMENTS

We have enjoyed the experience of working with our friends and colleagues, the divisional medical officers, who in their dual role bore the full burden of toil and anxiety. We thank them for their team spirit and praise their courage in persevering with what was for a time an unpopular vaccination policy.

Our thanks are also due to the County Council medical, nursing and clerical staff who provided valuable assistance as well as to those who volunteered to assist but were not called upon.

We are grateful too for the excellent co-operation of the Leeds Regional Hospital Board's officers and consultants and all our colleagues in County Boroughs involved in the outbreak.

Although at times our objective has been misunderstood by some general practitioners we wish to record with appreciation the way in which the general practitioner representatives of the Local Medical Committee readily accepted our explanation.

APPENDIX A

COUNTY COUNCIL OF THE WEST RIDING OF YORKSHIRE

MEDICAL OFFICER'S DEPARTMENT

To Divisional Medical Officers

Circular No. 14/62

BRADFORD SMALLPOX OUTBREAK—JANUARY, 1962

BULLETIN No. 2

The present situation according to information from Bradford and elsewhere is that there is now a total of 11 cases, with either a confirmed or provisional diagnosis of smallpox. These consist of the probable source (the Pakistani girl) and 10 secondary cases, comprising six children, one nurse, one visitor to the ward, one cook and a pathologist.

There have been four deaths, namely the source, the cook, the visitor, and one of the children.

We understand that none of the secondary cases showed evidence of previous successful vaccination but there is some doubt as to whether the original case was vaccinated, although there is a history of this having been done in Pakistan.

The only serious incident in the county area was the death yesterday of a Yeadon man in Otley General Hospital who developed what appeared to be either a viræmia or a septicæmia two days after a gastrectomy. In view of the similarity of the clinical picture to the fulminating type of smallpox the case is being treated administratively as one of smallpox until the results of virological tests are available. If this death is confirmed as being due to smallpox it will undoubtedly complicate the situation since there is no apparent connection between this man and the Bradford cases. The Otley General Hospital has been closed by the Regional Hospital Board to visitors and new admissions, and a long list of possible contacts including out-patients has been prepared and distributed by Dr. Burn to the appropriate Medical Officers of Health. As in earlier instances and at his request we have assisted him with the distribution.

Large numbers of direct contacts are now being ascertained, vaccinated and visited daily, the heaviest burden being carried by Dr. Burn and Dr. Battersby.

As indicated in my last circular a reserve of vaccinated doctors, nurses and clerks has been organized at this office and we have in addition approached the heads of other departments for clerical volunteers to be available in any part of the county area. Twenty or more of these are being vaccinated this afternoon and more are expected tomorrow. Additional clerical assistance will be necessary in any division where there is a large number of contacts to be visited daily, as accurate recording and documentation must be guaranteed. An approach has already been made to Divisional Medical Officers of areas not yet seriously affected to allow one or more of their Assistant County Medical Officers and Health Visitors to work in other areas. Very considerable assistance was given in this way to Bradford during the week-end but today some of this reserve staff has been diverted to the Horsforth and Shipley divisions. It is possible, indeed likely, that as tertiary cases arise this week-end some Divisional Medical Officers will be asked to give still further assistance in the West Riding area. I would advise the Divisional Medical Officers likely to be approached to reduce their commitments for the next week or two to the minimum.

It is extremely unlikely that we shall increase the present restricted scale of assistance afforded to Bradford Health Department, priority being given to our needs in the county area.

An additional drain on our manpower is threatened by the public demand for vaccination sessions but I hold strongly to the view expressed in my last circular and since supported by the Chief Medical Officer of the Ministry of Health that mass vaccination should only be adopted as a policy when the situation becomes out of control.

Not only does mass vaccination divert medical and other staff from the more urgent and much more important task of surveillance, but may also confuse the general picture by throwing up a large number of reactors with pyrexia and rash necessitating the appropriate medical investigation and precautionary measures, so multiplying the difficulties of the Medical Officer of Health. It is felt that the present outbreak should be capable of being controlled by the modern technique of ensuring that there is a ring of immune persons around every contact before he or she reaches the end of the incubation period. I am nevertheless aware in spite of these considerations that divisions bordering on Bradford may still find it difficult to resist the pressure of public demand for an indefinite period.

The problem may well be solved by a shortage of vaccine lymph. The demand has been far heavier than in any previous comparable outbreak due mainly to the fact that areas relatively remote from the centre of the outbreak are requesting huge supplies. Some of the demand would appear to come from general practitioners and the rest from authorities running entirely unnecessary public sessions. One can foresee the likelihood of some directive from the Ministry on the distribution of lymph, priority being given to areas requiring the vaccine for the protection of contacts.

One of the factors in this outbreak is the large number of hospitals directly affected and because of the many queries from the press and members of the public about affected hospital services the Leeds Regional Hospital Board have set up a publicity section designed primarily to meet requests for information from newspapers. If therefore you are asked for information about hospitals by the press we suggest that you refer them to the Leeds Regional Hospital Board, telephone number, Harrogate 5061, ext. 35.

I will continue to keep you informed of further developments.

RONALD W. ELLIOTT,

15th January, 1962.

County Medical Officer.

P.S.—For the benefit of Divisional Medical Officers in the Leeds Region I enclose a copy of Dr. C. W. Dixon's "Diagnosis of Smallpox" which may be of value to their medical staff.

A supply was made available by the University of Leeds Department of Preventive Medicine, but unfortunately there are insufficient for all Divisional Medical Officers.

APPENDIX B

COUNTY COUNCIL OF THE WEST RIDING OF YORKSHIRE

MEDICAL OFFICER'S DEPARTMENT

To Divisional Medical Officers

Circular No. 16/62

BRADFORD SMALLPOX OUTBREAK—JANUARY, 1962

BULLETIN No. 3

The only development today as far as the extension of the outbreak is concerned has been the admission to Ainsworth Hospital, in Lancashire, of a man aged 30 years who had visited Bradford Children's Hospital on 30th December. He is a Bingley resident who developed vague and atypical symptoms, including occipital headache, on 9th January and was seen by his doctor on 12th January. We understand that no rash was seen by the doctor but the man gave a history of a transient rash. He was vaccinated on 13th January as a contact and travelled to Manchester on 14th January. Here he had to consult a doctor because of his symptoms which included a pyrexia. The Manchester Medical Officer of Health in view of the man's previous contact with the Bradford Children's Hospital rightly decided to treat this man as a case of "administrative smallpox."

There is, of course, a large number of contacts in Dr. Battersby's area and these are being followed up, vaccinated and placed under surveillance. No other new cases or suspected cases have to my knowledge arisen today in the county area or in Bradford.

No final laboratory report is yet available in respect of the Otley Hospital patient who died on Sunday last but we learn this afternoon that no growth has yet been obtained by the virologist after two days of virus culture. A complement fixation test is negative; this is considered to be encouraging.

Another false alarm (not previously mentioned) arose from the death a few days ago of a Golcar child with meningococcal septicaemia ? viræmia. Virological tests for smallpox have been proved entirely negative.

The work of surveillance of contacts appeared to be continuing in the areas affected, especially in the Horsforth and Shipley divisions, and additional medical, nursing and clerical staff from other divisions and from the central office have been diverted to these divisions to meet their urgent needs.

Additional reserves of staff are available to meet any other developments.

I referred in yesterday's bulletin to the relative shortage of vaccine lymph. This position continues but I have sought and obtained an assurance from Dr. Conybeare that we shall have sufficient lymph for our essential needs, that is for the " ring " vaccination of known contacts. The supplies will *not* be adequate for mass vaccination of members of the general public who are not at special risk and it is almost certain that those authorities who have already arranged public sessions will have to discontinue them.

Every effort is being made to advise the press of the undesirability of mass vaccination and no doubt you will exert your influence with your local press.

RONALD W. ELLIOTT,
County Medical Officer.

16th January, 1962.

APPENDIX C

Form for Documentation of Contact Surveillance

PRIMARY CONTACT

(N.B.—“ Primary contact ”=person in direct contact with patient on or after 10th day of patient's incubation period.)

RECORD OF DAILY SURVEILLANCE

Name

Address

..... Age.....

Contact of.....(Name of Patient).

at.....

(Place of contact).

on.....

(Date or dates of contact).

Circumstances of contact (duration, proximity, etc.).....

Vaccinal history before contact.....

RECORD OF VISITS

Date	No. of Days Since First Contact	No. of Days Since Last Contact	Vaccination after Contact V = Vaccinated V Rep. = Vaccination Repeated S = Successful (Vesicle) N = Negative or Doubtful	Symptoms or Pyrexia	Eruption Details (if any)	Comments (if any) and initials of MO/HV
	1					
	2					
	3					
	4	(and on to 20 days)				

Note temperature from 10th day after *first* contact with patient (leave thermometer at house). On 16th day after *last* contact—

- (1) Verify last day of contact.
- (2) Check carefully for any sparse modified eruption, especially extremities and pressure points (bony points, tendons, etc.).
- (3) Ensure pyrexia and symptoms still absent.

SECONDARY CONTACTS

(i.e. members of household and others likely to be in contact with primary contact at end of presumptive incubation period).

Name	Address (if different from above)	Date of Vaccination	Result	Details of Repeat Vaccination

APPENDIX D

COMPLICATIONS OF PRIMARY VACCINATION AGAINST SMALLPOX

Statistics collated from Annual Reports of the Chief Medical Officer of the Ministry of Health for the years 1950–60 inclusive.

A. Generalized Vaccinia

Incidence and Mortality	AGE AT TIME OF PRIMARY VACCINATION			
	Under 1 year	1–4 years	5–14 years	15 years and over
Total primary vaccinations ...	2,841,254	539,302	286,471	446,708
Cases reported	137	16	8	30
Incidence per 100,000 primary vaccinations in respective age group	4·8	3·0	2·8	6·7
Deaths reported... ..	11	—	—	—
Mortality per 100,000 primary vaccinations in respective age group	0·39	—	—	—

B. Post-Vaccinal Encephalomyelitis

Incidence and Mortality	AGE AT TIME OF PRIMARY VACCINATION			
	Under 1 year	1-4 years	5-14 years	15 years and over
Total primary vaccinations ...	2,841,254	539,302	286,471	446,708
Cases reported	41	3	7	11
Incidence per 100,000 primary vaccinations in respective age group	1.4	0.6	2.4	2.5
Deaths reported... ..	17	1	—	1
Mortality per 100,000 primary vaccinations in respective age group	0.60	0.19	—	0.22

C. Post-Vaccinal Mortality (all causes)

	AGE AT TIME OF PRIMARY VACCINATION	
	Under 1 year	Over 1 year
Total primary vaccinations	2,841,254	1,272,481
Deaths ascribed to:—		
Vaccinia	11	—
Encephalomyelitis	17	2
Other causes	2	1
TOTAL DEATHS	30	3
Mortality per 100,000 vaccinations in each age group ...	1.06	0.24

It is gratifying to report that many of the points raised, particularly in regard to the optimum age for primary vaccination, have since been adopted by the Ministry of Health as the recognised procedure to be followed in the event of future outbreaks.

VACCINATION AGAINST SMALLPOX:

The following table shows the number of vaccinations and re-vaccinations performed during the years 1959-1962:—

Vaccinations							Re-Vaccinations					
Year	Under 1	1	2-4	5-14	15 or over	Total	Under 1	1	2-4	5-14	15 or over	Total
1959	9,563	909	431	365	751	12,019	5	7	56	175	1,237	1,480
1960	6,857	946	480	419	780	9,482	2	5	39	212	1,264	1,522
1961	5,250	2,053	720	502	746	9,271	2	14	79	280	1,497	1,872
1962	9,919	7,385	12,540	35,411	43,806	109,061	37	143	3,210	26,818	81,493	111,701

Nine cases of generalised vaccinia and three cases of post-vaccinal encephalomyelitis were reported and all followed vaccinations performed because of the prevalence of smallpox in the Bradford area.

Generalised Vaccinia :

Eight of the reported cases were associated with primary vaccination, the ages being 23 months, 6, 8 (two cases), 11, 28, 50 and 55 years, and two cases were in children suffering from eczema. The ninth case was of a 19 months old female following re-vaccination. None were fatal.

Post-vaccinal Encephalomyelitis :

The ages of the three cases, who had been previously vaccinated, were 1, 7 and 16 years. One case (1 year) was referred to the family doctor on the 10th February, admitted to hospital on the same day and discharged on the 28th February. General reactions in the second case (16 years) were reported from hospital on the 13th March, 1962, as follows:— “ Diffuse transverse myelitis with transverse lesion level at T5-6. Diffuse lesions especially affecting left leg with typical cerebro-spinal fluid changes—protein 180 mgm % cells 4 per cu.mm. Symptoms commenced 14th February, 1962. Patient is still an in-patient but is progressing very satisfactorily ”.

The third case, a girl of 7 years, was fatal. The child was vaccinated on 17th January, 1962, and was “ off colour ” 25th, 26th and 27th January with headache and vomiting. Became delirious 28th January. Comatose 28th January. Admitted to hospital on 29th January. Cerebro-spinal fluid normal. At the post mortem the only positive findings were marked œdema and hyperæmia of the brain, a marked purulent bronchitis and multiple hæmorrhagic areas in lungs. Histology showed this to be severe vascular congestion with some areas of hæmorrhages. No inflammatory exudate. The liver was pale and fatty.

Two cases of eczema vaccinatum due to accidental heterogenous vaccination were reported—one of a man, who was a life long sufferer from chronic eczema and had just got over an acute phase, whose wife had been vaccinated, and the other was a known eczematous subject who had been in contact with a vaccinated friend.

Acute Encephalitis:

Cases of the disease are classified as “ post-infectious ” if accompanying or following infectious disease or smallpox vaccination; in instances when no such relationship is established the classification of “ infective ” is made. Confirmation of diagnosis was made in six cases; two infective and four post-infectious.

None of the cases had any apparent connection. Of the post-infectious cases, one each was associated with mumps and chicken pox, and two followed primary smallpox vaccination. In addition to the latter cases a fatal case of post-vaccinal encephalitis occurred. The case was not notified but post-mortem findings were “ cerebral complication of vaccination ”.

Enteric Fevers:

TYPHOID FEVER:

In 1941, typhoid and paratyphoid fevers became separate entities for notification purposes. Since that time the annual number of notifications of typhoid fever has fluctuated within the range of nil to 27; in 1962, the diagnosis was confirmed in two cases.

The first case was of a woman of 54 years who took ill with vague abdominal pains, pyrexia, etc., and was subsequently admitted to hospital. An agglutination test gave the following results, S. Typhi "H" 1/1250, S. Paratyphi A "H" 1/50, S. Paratyphi B "O" 1/125. The case was thoroughly investigated but specimens of food and from contacts were negative, and the source of infection remains untraced.

The second case was of an Italian girl of 8 years who fell ill 8 days after arrival in this country. She was admitted to hospital where phage type D.1 was isolated. Specimens of food and from family and other contacts were repeatedly negative, and it is presumed she brought the infection from Italy.

In my Report for 1961 I referred to the decision reached in regard to the advising of school parties proposing to holiday in countries bordering on the Mediterranean Sea and certain parts of Europe to receive preventive inoculation against typhoid and paratyphoid fevers. The arrangement has worked well and no incidents were reported.

PARATYPHOID FEVERS:

Confirmation was made in 11 cases, all Salm. paratyphi B, the age-sex distribution of which appears on page 47.

Two sisters aged 12 and 15 years were admitted to hospital in January and March respectively where the organism was isolated from stool specimens. It is presumed that both received the infection from their mother who was an excreter.

There were two sporadic cases, a female of 16 years, who had been on holiday in Paris and a 26 year old female who fell ill after visiting Italy. It is likely that both were infected abroad.

Reporting on five cases in the same family, Dr. Russell, Divisional Medical Officer (Wortley) commented:

" On the 30th June, I was informed by the City General Hospital, Sheffield Laboratory that three faecal samples from a family were almost certainly positive for S. paratyphi B and Dr. Armstrong, my Deputy, immediately visited the home to find that no members of the family had been particularly ill, their only complaint having been a mild diarrhoea of about two days duration, affecting the mother, father and their three children. The youngest child had this type of diarrhoea during the last week in May. On the 9th June the family set off for a camping holiday on the Continent where they spent a fortnight and arrived home on the 23rd June. Their itinerary on the Continent was as follows:—

Ostend 2 nights—Koblenz (Germany) 2 nights—Augsburg-Ost 1 night—St. Wolfgang (Austria) 3 nights—Innsbruck 3 nights—Maersburgh (Germany) 1 night—Luxemburg 1 night—De Panne (Belgium) 1 night.

The father and mother both had diarrhoea on the 24th June, without feeling particularly ill. The two elder children also had this mild type of diarrhoea during the next three or four days.

The diet and drink of the family was fully discussed but there was no leader as to what might have been the source of infection. All five of the family have since proved to be positive for paratyphoid B. It is, therefore, possible that the youngest child who had diarrhoea at the end of May infected the rest of the family and obviously no-one can remember what she had to eat at that time. There is no connection with the two or three local cases, i.e., in Sheffield.

From a preventive point of view I considered that even in the absence of illness it was much preferable for the family to go into hospital until such time as their stools were clear of infection.

Living with the family was the maternal grandfather who was consistently proved to be free from the infection. The son was not admitted to hospital until a positive stool was recorded on the 3rd July. Between 30th June and 3rd July the paternal grandmother, who

lives in Doncaster C.B., came to look after the boy. She also proved to have a positive stool, but had not had diarrhoea. She agreed to go into hospital and elected to go to the hospital near her home. I telephoned this information to the Medical Officer of Health who arranged to have specimens examined from the paternal grandfather.

The only person who had visited the house and had food was a female student. The Medical Officer of Health for the area at which she was at college dealt with that problem.

This was a mild type of Paratyphoid Enteritis occurring in one family. One possibility was that the paternal grandmother was a carrier. Faecal samples were taken at regular intervals from the cases and negative results were not obtained until early November. In spite of all the investigations carried out the source of the infection was not determined."

Two connected cases were notified in September. The first, a four year old girl, was admitted to hospital where the initial diagnosis was confirmed. Home investigations revealed that a party had been held at the patient's home on the 25th August and further investigations were made at the homes of each of the contacts. Faecal specimens were submitted from the contacts and as a result a further case, a girl aged three years, was discovered. The remaining contacts proved to be negative. The normal suspected foodstuffs were also sampled and faecal specimens were also taken from food handlers in the parish all of which proved to be negative. Again, the vehicle and source of infection remained untraced.

Food Poisoning:

Information in regard to the incidence of food poisoning has been obtained from the statutorily notified cases and the reports of Medical Officers of Health on outbreaks and associated investigations. Notifications only numbered 56 but additionally 226 cases were ascertained during the course of investigations, a total of 282 incidents compared with 362 in 1961, and an annual average of 419 in the period 1957-61.

The main microbial causes are given in the following table:—

Presumed Causal Agent	Family Outbreaks		Other Outbreaks		Sporadic Cases	Total Cases
	Number	Cases Involved	Number	Cases Involved		
Salmonella Typhimurium	2	8	1	12	42	62
Other Salmonellæ	—	—	—	—	7	7
Cl. Welchii	1	2	4	132	—	134
Staphylococci	—	—	—	—	48	48
Other organisms	—	—	—	—	10	10
Not discovered	2	7	1	6	8	21
All agents	5	17	6	150	115	282

In addition there were two symptomless excreters reported.

The reduction in incidence was most marked during the first three quarters of the year; indeed, 46 per cent. of the incidents arose in the last quarter.

The number of incidents involving salmonellæ increased appreciably as compared with the previous year; the foods responsible, however, were not identified conclusively. Studies into the various sources and modes of spread of salmonellosis continue. The main sources of infection are infected rodents and poultry. Human carriers play an important secondary role if they handle food for consumption by others. Among the suspected vehicles of infection are unpasteurised bulked liquid egg, contaminated animal feeding stuffs and infected implements and machinery used in the preparation of food.

There were five outbreaks due to *Cl. welchii* involving a total of 134 cases. One of the outbreaks of 82 cases appeared to have originated in a school canteen and Dr. Douglas, Divisional Medical Officer (Spenborough) kindly supplied the following summary:

“Lunch prepared at an infants school canteen consisting of Yorkshire pudding, mashed potatoes, frozen peas, mutton, rice pudding, fresh fruit, tinned pineapple pieces, tin of cherries, banana, grapes and apples was served on 20th November to pupils and staff at three schools where the estimated number of consumers at risk was 219.

At varying intervals of between 7 and 18 hours after having the meal many consumers complained of abdominal pain and diarrhoea which, fortunately, was not generally severe and lasted for a duration of 24 hours.

A sample of the entire meal was submitted for bacteriological examination and heat resistant *clostridium welchii* was cultured from the roast mutton and from the gravy, the latter having a particularly heavy growth. No pathogenic organisms were cultured from the remainder of the samples submitted.

Fæcal samples were obtained from ten persons suffering from the disease. All of these had positive cultures of heat resistant *Cl. welchii* and in all 82 cases were ascertained. In addition, fæcal samples were obtained from all eleven members of the kitchen staff concerned; these too gave positive cultures of heat resistant *Cl. welchii*.

The mutton consumed (New Zealand frozen) was delivered from the butchers on the 19th November and was kept in the refrigerator until 7-30 a.m. on the following day, when it was cut into smaller joints (less than 6lb. weight) and put into the oven for roasting. At 11 a.m. the meat was taken from the oven and sliced ready for delivery in metal containers. The meal was consumed in the schools concerned between 12 noon and 12-30 p.m. There was, therefore, no unreasonable delay between cooking and consumption, and in the light of this it appears unlikely that this meat could have been the source of infection. The gravy was also prepared on the same day using flour and fat from the meal cooked that day, and again there was no unreasonable delay between preparation and consumption. However, the cooking fat used in the kitchen was an accumulation of fat from previous meals and from fat rendered down, and it is possible that this may have been used in the preparation of the meal, particularly of the gravy. If this was previously contaminated it is likely that its use on this occasion was the cause of the outbreak. Unfortunately, before I became aware of this possibility the accumulation of fat had been destroyed and it was not, therefore, available for sampling. The laboratory reports, however, indicated a particularly heavy growth of *Cl. welchii* from the gravy cultures. It is, I understand, normal household practice to accumulate cooking fat in this way and in the light of the present outbreak it would appear to be undesirable practice in school kitchens for the future.”

With the co-operation of the Chief Education Officer the procedure at various school kitchens was investigated and, although samples of accumulated fat gave negative bacteriological results, he issued a memorandum to school meals supervisors, cook-supervisors and cooks as follows:—

“If the risk of food poisoning is to be avoided the following instructions about clarifying dripping must be carried out.

To clarify dripping

1. Put the fat in a pan with water.
2. Cover with a lid and bring slowly to the boil.
3. Allow to cool and pour off water.
4. Scrape off and throw away all sediment and brown jelly on bottom of fat.
5. Melt fat again and heat gently to drive off all water (i.e., until it stops bubbling).
6. When cool pour fat into baking tin, put a lid on and store in refrigerator or cold room.

Note

1. It is the sediment and jellied meat juice on the bottom of blocks of dripping that constitute a risk of food poisoning and it is essential that this be thrown out.
2. Each time fat is rendered down it must be clarified as described above and stored *in a separate tin not added to* already clarified dripping.
3. The tins of dripping should be used in order.

Cooks, assistant cooks or any other member of the kitchen staff who may carry out this job should read and sign this circular.

Supervisors and cooks in charge should note that any disregard of these instructions will be viewed most seriously by the County Council."

Ophthalmia Neonatorum:

In the Ophthalmia Neonatorum Regulations the disease is defined as "a purulent discharge from the eyes of an infant commencing within 21 days from the date of its birth". Should cases arise it is imperative that treatment should be administered promptly if impaired vision or total blindness is to be prevented. Since 1950 the number of notifications has fallen considerably: in 1962 only 3 cases were notified, each case responding to treatment with no impairment of vision.

Puerperal Pyrexia:

In 1951, revised Regulations were introduced defining puerperal pyrexia as "any febrile condition occurring in a woman in whom a temperature of 100·4°F (38°C) or more has occurred within fourteen days after childbirth or miscarriage." Since then notifications have averaged 104 per annum compared with 51 in 1962.

Anthrax:

The disease became generally notifiable on 1st December, 1960, under the Public Health (Infectious Diseases) Amendment Regulations, 1960. Since then four cases have been notified; two in 1960, one in 1961, and one in 1962. The latter case, a male of 64 years, developed a small spot on the lower lip; he was referred to a consultant dermatologist who considered the case to be clinical anthrax although the organism was not isolated, possibly due to treatment with antibiotics before the tests could be made. The patient was employed as a wool blender, handling raw wool, at a carpet works in a neighbouring County Borough and details were referred to the medical officer of health who undertook investigations but the source of infection was not traced. Although the patient's pustule reached a diameter of 1¼ inches, with antibiotic treatment he made a complete recovery.

The procedures for referring all cases of suspected anthrax for immediate medical advice have continued at factories, warehouses and docks where materials with an anthrax risk are handled. Revised lists of firms and factories concerned, also the hospitals to which suspected cases should be sent for diagnosis were issued to medical officers of health and general practitioners. The firm at which the above case worked was on the list and their awareness of the hazard enabled the patient to be referred for treatment with minimum delay.

Influenza :

Although not a notifiable disease, prevalence is reflected in the increase in the weekly returns of new claims to sickness benefit issued by the Ministry of Pensions and National Insurance, school absenteeism, notifications of pneumonia and deaths attributed to influenza.

During December, 1961, there was a period of severe weather and a number of incidents, patchy in character, were reported in the north of the Riding within a triangle Skipton, Ripon and Harrogate, gravitating to Pudsey, also in the Rotherham district. A variety of infections were prevalent including influenza types A and B, Coxsackie and Echo viruses, singly and in combination, with influenza B the most frequently isolated. This pattern of infection continued in the northern parts of the Riding until mid-January.

Various districts in the Calder and Aire Valleys reported increased new claims to sickness benefit during the last two weeks of January. This period coincided with the smallpox outbreak and enquiries revealed that whilst influenza and bronchitis were still fairly prevalent a contributory factor was undoubtedly the number of sickness certificates in which the cause was returned as "vaccine fever" or "reaction following vaccination."

Incidence remained low throughout the remainder of the year with no outbreaks of any significance reported.

TUBERCULOSIS

Deaths from Tuberculosis:

There were 91 deaths from tuberculosis (80 respiratory and 11 non-respiratory), representing a death rate of 0·054 (0·048 respiratory and 0·007 non-respiratory), which corresponds with the England and Wales death rate of 0·066 (0·059 respiratory and 0·007 non-respiratory). Details of deaths are given in the following table:—

Table.

Classification	Age at Death in Years																Total		Grand Total
	0—		1—		5—		15—		25—		45—		65—		75—				
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
Respiratory ...	—	—	—	—	—	—	—	—	4	5	28	6	23	1	12	1	67	13	80
Non-respiratory	—	—	—	—	—	—	—	1	—	1	1	1	4	2	—	1	5	6	11
Totals ...	—	—	—	—	—	—	—	1	4	6	29	7	27	3	12	2	72	19	91

Notification of Tuberculosis:

There were 512 primary notifications of tuberculosis arising during the year and 21 supplemental notifications, a total of 533 as compared with 639 (616 primary and 23 supplementary) notifications in 1961. Details of the new cases are summarised in the following table:—

		AGE PERIODS													Total all Ages
		0-	1-	2-	5-	10-	15-	20-	25-	35-	45-	55-	65-	75-	
FORMAL NOTIFICATIONS:															
Respiratory, Males	...	-	2	3	5	7	17	20	45	43	62	63	43	12	322
Respiratory, Females	...	-	-	2	1	4	11	22	31	21	14	11	7	5	129
Non-Respiratory, Males	...	-	1	2	2	2	2	3	8	2	2	1	2	-	27
Non-respiratory, Females	...	-	-	2	3	-	4	5	7	6	3	2	1	1	34
															512
SUPPLEMENTAL NOTIFICATIONS:															
Respiratory, Males	...	-	-	-	-	-	-	-	-	-	1	2	4	6	13
Respiratory, Females	...	-	-	-	-	-	-	1	-	-	1	-	2	1	5
Non-respiratory, Males	...	-	-	-	-	-	-	-	-	-	-	-	2	1	3
Non-respiratory, Females		-	-	-	-	-	-	-	-	-	-	-	-	-	-
															21

The sources of information of the supplemental notifications were Local Registrars (10 respiratory), transferable deaths from the Registrar General (6 respiratory and 2 non-respiratory), and posthumous notifications (2 respiratory and 1 non-respiratory).

Register of Cases:

After adjustments for removals, recoveries and deaths, the total number of notified cases of tuberculosis on our register at the end of the year was 9,121, a decrease of 444 compared with the previous year. The following table summarises the revision of the registers in the respective divisional areas:—

Div. No.	on register 1st January, 1962				added to register				removed from register				remaining on register 31st December, 1962				Per 1,000 Popu- lation	
	Respiratory		Non-Res- piratory		Respi- ratory		Non-Res- piratory		Respi- ratory		Non-Res- piratory		Respiratory		Non-Res- piratory			Total
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
1	214	141	34	36	16	8	1	14	14	6	6	216	135	29	31	411	5.1	
3	257	140	46	36	29	9	3	67	38	28	9	219	111	21	29	380	6.8	
4	194	113	11	19	25	20	2	25	18	1	—	194	115	12	22	343	5.1	
5	342	224	43	50	22	15	3	28	14	2	1	336	225	44	55	660	5.7	
7	237	185	32	46	22	18	1	23	29	6	8	236	174	27	40	477	4.5	
9	73	57	13	12	9	6	—	3	3	—	—	79	60	13	13	165	3.4	
10	143	115	19	26	5	3	—	6	9	2	2	142	109	17	24	292	6.6	
11	212	145	14	16	10	6	1	15	16	—	2	207	135	15	14	371	6.3	
12	227	162	38	50	14	5	—	16	11	—	2	225	156	38	49	468	7.7	
13	136	87	12	31	10	9	1	24	24	3	4	122	72	10	28	232	2.7	
15	54	50	35	16	23	11	3	15	12	—	4	62	49	38	16	165	3.4	
16	103	89	16	17	12	3	1	15	10	—	5	100	82	17	12	211	3.7	
17	60	34	8	13	5	—	4	11	7	2	1	54	27	10	13	104	2.1	
18	207	131	13	3	11	14	1	26	15	3	—	192	130	11	3	336	5.7	
19	166	127	20	22	27	14	—	27	27	1	5	166	114	19	19	318	6.0	
20	191	134	23	40	21	11	5	37	40	6	10	175	105	22	31	333	3.7	
23	245	181	27	37	16	7	—	21	12	1	5	240	176	26	33	475	7.1	
Leeds R.H.B.	3,061	2,115	404	470	277	159	26	26	373	299	61	64	2,965	1,975	369	432	5,741	5.0
22	345	213	75	54	33	10	1	23	7	—	1	355	216	76	55	702	7.7	
25	224	156	37	27	25	12	—	20	8	—	—	229	160	37	28	454	6.0	
26	394	263	48	61	33	13	3	47	33	6	6	380	243	45	56	724	6.6	
27	350	304	83	58	44	21	2	50	25	1	2	344	300	84	62	790	7.2	
29	138	120	37	34	11	7	1	41	34	5	11	108	93	33	23	257	7.3	
31	256	170	37	31	20	12	3	34	37	5	4	242	145	35	31	453	4.8	
Sheff. R.H.B.	1,707	1,226	317	265	166	75	10	14	215	144	17	24	1,658	1,157	310	255	3,380	6.6
West Riding	4,768	3,341	721	735	443	234	36	40	588	443	78	88	4,623	3,132	679	687	9,121	5.5

Care and After-Care of the Tuberculous:

The ancillary services provided by the County Council are briefly summarised as follows:—

Extra nourishment, consisting of up to two pints of milk daily, continues to be available for domiciliary patients suffering from active tuberculosis; a total of 926 patients were granted free milk during the year and 557 persons were still on the register at 31st December.

Domiciliary open-air shelters, beds, mattresses and bedding are provided to facilitate the segregation of the tuberculous patient who resides at home, but, due to better housing conditions, there is now little demand for the foremost.

During 1962, 2 patients, whose condition did not permit of their return to normal competitive employment, were admitted to the training settlement at Sherwood, and one patient was re-admitted to Papworth Village Settlement after a period of hospital treatment. There was one discharge from Papworth and at the end of the year there were 9 patients still in residence—at Papworth (2) and at Sherwood (7).

CARE COMMITTEES:

Any review of Care and After-Care Services would be incomplete without reference to the work undertaken by Tuberculosis After-Care Committees. The work of a Care Committee is directed at easing the problems, both financial and otherwise, with which the tuberculous patient and his family have to contend. Because of their composition, the Committees are well-fitted for this task, for, in addition to laymen who are sympathetic towards the problems of the tuberculous, there are, serving with the Committees, persons who have specialised knowledge, e.g., Divisional Medical Officers, Chest Physicians, representatives of the National Assistance Board, etc., who are able to advise patients in need of help of the facilities available from statutory sources. This "expert" advice does tend to conserve the Committees' funds and ensures that help is given only to those patients and their families who are outside the scope of help provided by the statutory bodies. There are ten such Care Committees active in the West Riding area, three of which serve areas which include a county borough. The Care Committees provide services in thirteen divisional areas and cover approximately half of the County population. Their work is actively encouraged by the County Council who provide grants in aid to supplement the financial resources of the Committees; the grants for this year amounted to £1,035. These grants are distributed amongst the Committees according to the population served and the amount of expenditure upon benefits to patients. Many of the Committees have extended their activities to include the after-care of patients suffering from other chest diseases and heart conditions, and this extension of activity has resulted in an increased demand upon the resources of the Committees.

B.C.G. Vaccination:

Details of B.C.G. vaccination given to the various categories under Section 28 of the National Health Service Act are shown below:—

(a) CONTACTS.—A further 1,588 contacts were vaccinated, 13 of them being unsuccessful. Full details are shown in the following table:—

					AGE GROUPS												All Ages
					Under 1 year Months				Years								
					0-	1-	3-	6-	1-	2-	3-	4-	5-	10-	15-	20-	
Vaccinated:																	
Male	...	...	...	...	100	80	76	45	59	55	30	29	114	100	39	82	809
Female	...	...	...	...	83	73	73	44	65	49	45	57	105	92	35	58	779
TOTAL	...	...	...	...	183	153	149	89	124	104	75	86	219	192	74	140	1,588
Result of Vaccination:																	
Successful:																	
Male	...	...	...	...	92	69	68	38	46	43	22	24	92	79	30	80	683
Female	...	...	...	...	72	54	63	35	53	41	38	46	91	68	30	49	640
TOTAL	...	...	...	...	164	123	131	73	99	84	60	70	183	147	60	129	1,323
Unsuccessful	...	...	...	...	2	4	-	-	—	2	-	3	1	—	-	1	13
Not finally ascertained	...	...	...	...	17	26	18	16	25	18	15	13	35	45	14	10	252

(b) SCHOOL CHILDREN.—Twelve thousand and twenty were vaccinated under the County scheme, and the following is a summary of the work in the 22 divisions involved.

Acceptances:

Number of children offered tuberculin testing and vaccination if necessary	25,054
Number found to have been vaccinated previously	108
Number of acceptances	16,669
Percentage of acceptances	66.8

Pre-vaccination tuberculin test:

Number of children tested	...	...	...	...	...	...	15,638
Result of test:							
				<i>Heaf Test</i>	<i>Mantoux Test</i>		
Positive	...	...	...	2,507	425		
Negative	...	...	...	8,720	3,411		
Not ascertained		...	...	514	61	Total	15,638
Percentage positive	...	...	...	22.3	11.1	...	19.5

Vaccination:

Number vaccinated—

Following negative Heaf Test	8,653			
Following negative Mantoux Test	3,367	Total	...	12,020

Tuberculin test twelve months after vaccination:

Number tuberculin tested after 12 months	...	...	...	2,667
Result of test—				
Positive	...	...	...	2,416
Negative	...	...	...	137
Not ascertained	...	...	...	114
			Total	2,667

(c) STUDENTS ATTENDING UNIVERSITIES, TEACHER-TRAINING COLLEGES, TECHNICAL COLLEGES OR OTHER ESTABLISHMENTS FOR FURTHER EDUCATION.—Eleven students were tested, and the five who were found to be negative were vaccinated.

Mass Radiography:

Fifty eight thousand two hundred and sixty two persons from the Administrative County were examined by the Mass Radiography Service, 43,053 by units of the Leeds Regional Hospital Board and 15,209 by the Sheffield Regional Hospital Board. It will be seen from the tables below that 97 (0·17 per cent. of the total examined) cases of active tuberculosis, and 248 (0·44 per cent.) cases of inactive tuberculosis were discovered; there were also 843 (1·45 per cent.) non-tuberculous abnormalities found, 358 (42·47 per cent. of the total non-tuberculous abnormalities) of which were cases of pneumoconiosis. When separated into the two hospital regions, the percentage of cases of pneumoconiosis was 51·21 in the Sheffield Region, and only 23·19 in the Leeds Region.

A.—LEEDS UNITS

Survey undertaken in Division No.					Number Examined	Abnormalities Discovered			
						Tuberculosis		* Other	Total
						Active	Inactive		
1	(Skipton)	...	...	...	3,594	5	12	26	43
3	(Keighley)	...	...	...	130	1	—	2	3
4	(Shipley)	...	...	...	6,588	24	30	43	97
5	(Horsforth)	...	...	...	2,892	8	14	10	32
7	(Harrogate)	...	...	...	5,114	7	5	9	21
10	(Goole) ...	...	...	...	1,655	1	2	7	10
11	(Castleford)	...	...	...	3,922	3	4	20	27
12	(Pontefract)	...	...	...	94	—	—	—	—
13	(Morley)...	...	...	...	3,516	5	4	18	27
15	(Batley) ...	...	...	...	3,287	15	11	15	41
19	(Todmorden)	...	...	...	5,853	12	14	36	62
20	(Colne Valley)	...	...	...	3,017	4	9	21	34
23	(Hemsworth)	...	...	...	3,391	5	13	56	74
TOTALS ...					43,053	90	118	263	471

B.—SHEFFIELD UNITS

Survey undertaken in Division No.					Number Examined	Abnormalities Discovered			
						Tuberculosis		* Other	Total
						Active	Inactive		
22	(Wortley)	...	...	...	2,677	3	13	74	90
25	(Barnsley)	...	...	...	1,381	2	11	57	70
26	(Wath upon Dearne)	...	...	...	6,517	2	71	253	326
27	(Doncaster)	...	...	...	903	—	13	45	58
31	(Rotherham)	...	...	...	3,731	—	22	151	173
TOTALS ...					15,209	7	130	580	717

otals for the County Area ... 58,262 97 248 843 1,188

*Details of the 843 “ Other ” abnormalities are as follows:—

	Leeds Region	Sheffield Region
1. Abnormalities of bony thorax and soft tissues— congenital ...	—	17
2. Abnormalities of bony thorax and soft tissues— acquired ...	3	15

3. Tumours of the bony thorax; primary and secondary	—	—
4. Congenital malformation of the lungs	2	—
5. Bacterial and virus infection of the lungs ...	26	24
6. Other infections of the lungs	3	—
7. Bronchiectasis	30	17
8. Honeycomb lung	—	—
9. Emphysema	8	18
10. Pulmonary fibrosis—non-tuberculous	28	65
11. Pneumoconiosis	61	297
12. Spontaneous pneumothorax	—	—
13. Benign tumours of the lungs and mediastinum ...	6	5
14. Carcinoma of the lung and mediastinum ...	9	5
15. Metastases in the lung and mediastinum ...	—	1
16. Enlarged mediastinal and bronchial glands— non-tuberculous	1	—
17. Sarcoidosis and collagenous diseases	3	—
18. Pleural thickening or calcification—non-tuberculous	7	34
19. Abnormalities of the diaphragm and œsophagus— congenital and acquired	8	8
20. Congenital abnormalities of heart and vessels ...	13	9
21. Acquired abnormalities of heart and vessels ...	43	65
22. Miscellaneous	12	—
23. Inquiries not completed	—	—
	<hr/> 263 <hr/>	<hr/> 580 <hr/>

VENEREAL DISEASES

Contributed by Dr. J. A. Burgess, Consultant Venereologist.

The statistics given in the first half of this report have been taken from figures kindly provided by the medical officers in charge of special clinics, at which West Riding Administrative County residents attended during 1962. They do not represent the true incidence of venereal diseases and other conditions in the County but they give an indication of the trend of new infections.

Table A.

New patients.

Year	Syphilis	Gonorrhœa	Other Conditions	Total of New Patients
1938	346	650	503	1,499
1939	403	678	593	1,674
1940	299	499	497	1,295
1941	331	552	587	1,470
1942	423	479	735	1,637
1943	487	654	1,344	2,485
1944	413	560	1,383	2,356
1945	473	767	1,419	2,659
1946	723	1,140	1,859	3,722
1947	573	729	1,511	2,813
1948	463	550	1,403	2,416
1949	435	383	1,360	2,178
1950	357	304	1,447	2,108
1951	247	171	1,212	1,630
1952	219	211	1,275	1,705
1953	214	182	1,228	1,624
1954	178	152	1,189	1,519
1955	175	135	1,168	1,478
1956	155	99	1,143	1,397
1957	152	125	1,078	1,355
1958	124	138	1,129	1,391
1959	112	405	1,352	1,869
1960	83	338	1,550	1,971
1961	85	286	1,669	2,040
1962	69	244	1,623	1,936

The number of new patients decreased by 104 from 2,040 to 1,936.

Syphilis in the above table includes early infectious, late acquired and congenital syphilis. Cases of syphilis decreased by 16. The general trend of this disease since the year following the end of World War II has been downwards.

New cases of gonorrhœa attending special clinics were fewer by 42 in 1962. Unlike some of the West Riding county boroughs, the apparent incidence of gonorrhœa in the administrative county has fallen in the past three years. The 1962 total of 244 compares very favourably with pre-war numbers of well over 600. The administrative county is fortunate in having an excellent contact tracing service with the result that many contacts of known cases are found and brought under medical examination without delay.

Other conditions fell in number for the first time since 1957 from 1,669 to 1,623. Numerically this group is of considerable importance, comprising 84 per cent. of all new patients seen at special clinics.

The corresponding percentages for syphilis and gonorrhœa in 1962 were 3 per cent. and 13 per cent.

Table B.

Early and Congenital Syphilis.

Year	Early Acquired Syphilis	Congenital Syphilis under 1 year	Total Early Syphilis
1949	158	7	165
1950	76	4	80
1951	58	4	62
1952	19	1	20
1953	9	1	10
1954	7	—	7
1955	6	1	7
1956	9	—	9
1957	1	—	1
1958	5	—	5
1959	12	—	12
1960	—	—	—
1961	4	—	4
1962	4	1	5

A very few cases of early acquired (infectious) syphilis continue to be found in West Riding administrative county residents; but the remarkable fall in the apparent incidence (see Table B.) of this disease since 1949 is noteworthy. The prevention of the spread of early syphilis depends largely on the rapid and successful tracing and examination of contacts.

Unfortunately there was one case of early congenital syphilis in a baby whose mother failed to attend for adequate treatment during her pregnancy.

Table C.

Analysis of New Cases (quarterly and stage of disease).

Quarter ended	Acquired Syphilis				Congenital Syphilis				Gonor- rhœa		Other Conditions	
	Early		Late		Under 1 year		Over 1 year		1961	1962	1961	1962
	1961	1962	1961	1962	1961	1962	1961	1962				
31st March ...	1	—	17	18	—	—	1	3	64	59	387	388
30th June ...	—	3	22	12	—	—	5	2	71	58	388	390
30th September	—	—	13	12	—	1	4	2	71	62	426	366
31st December	3	1	15	13	—	—	4	2	80	65	468	479
	4	4	67	55	—	1	14	9	286	244	1,669	1,623

Table C gives the numbers of new cases of both acquired and congenital syphilis in the early and late stages, also gonorrhœa and other conditions diagnosed at special clinics during each quarter of 1962. The corresponding figures for 1961 are included for comparison. Late acquired syphilis fell in number by twelve and congenital syphilis over one year of age decreased by five.

As usual there were more cases of gonorrhœa in the last six months of the year than in the first two quarters.

Other conditions decreased in number by 46 compared with 1961.

Table D.

Distribution of New Cases by Treatment Centres.

Special Treatment Centre	Syphilis	Gonor- rhœa	Other Con- ditions	Total
Barnsley Clinic, Queen's Road	3	7	109	119
Bradford St. Luke's Hospital	3	30	101	134
Burnley Victoria Hospital	1	1	2	4
Dewsbury General Hospital	9	11	72	92
Doncaster Royal Infirmary	6	49	226	281
Goole Bartholomew Hospital	—	9	9	18
Halifax Royal Infirmary	6	6	75	87
Harrogate General Hospital	2	17	130	149
Huddersfield Royal Infirmary	2	7	76	85
Keighley Victoria Hospital	6	34	104	144
Leeds General Infirmary	11	49	250	310
Oldham Boundary Park General Hospital	—	2	4	6
Rotherham Moorgate General Hospital	4	4	117	125
Sheffield Jessop Hospital	—	—	5	5
Sheffield Royal Hospital	—	1	22	23
Sheffield Royal Infirmary	1	—	10	11
Sheffield City General Hospital	2	—	2	4
Wakefield Clayton Hospital	11	15	275	301
York County Hospital	2	2	34	38
	69	244	1,623	1,936

The addresses of special clinics at which new patients attended during 1962 and the number of cases of each disease diagnosed are given in Table D. These figures exclude patients who were transferred after diagnosis from one clinic to another, also patients who had defaulted from treatment in a previous year and returned during the year under review for treatment of the same disease.

New cases from the administrative county attended at 19 different special clinics during the year. Fourteen of these centres were in West Riding county boroughs, two in Lancashire and three in West Riding municipal boroughs.

Forty-six per cent. of all new patients attended the Doncaster, Leeds and Wakefield special clinics.

Of the cases of gonorrhœa 66 per cent. attended at Bradford, Doncaster, Keighley and Leeds.

Table E.
New Cases—Sex Distribution.

	Males	Females	Total
Syphilis	28	41	69
Gonorrhœa	185	59	244
Chancroid	—	—	—
Lymphogranuloma Venereum	—	—	—
Granuloma Inguinale	—	—	—
Non-gonococcal Urethritis	351	—	351
Yaws	—	—	—
Other Conditions requiring treatment	313	255	568
Not requiring treatment	478	222	700
Undiagnosed at 31st December, 1962	—	4	4

The above table shows the sex distribution of new patients with syphilis, gonorrhœa and other conditions.

Sixty per cent. of the patients found to have syphilis were females.

Of the patients with gonorrhœa over 75 per cent. were males. Each new infection was recorded as a separate case. The 244 cases of gonorrhœa represent a smaller number of individuals because some patients acquired the disease on more than one occasion during the year. There were no patients with chancroid, lymphogranuloma venereum, granuloma inguinale or yaws.

Non-gonococcal urethritis is the collective term for a group of conditions excluding gonorrhœa, in which there is inflammation of the male urethra. Many cases, but by no means all, follow sexual exposure. Trichomoniasis and inclusion blennorrhœa are probably the commonest venereal causes of non-gonococcal urethritis in men.

Of the 1,623 total “ other conditions ” 700 (43 per cent.) were found after examination not to be suffering from any disease requiring treatment.

V.D. Social Work:

The staff consists of four social workers who are all state registered nurses with health visitor’s certificates. The work comes under the immediate direction of the consultant venereologist who is adviser in venereal diseases to the County Council and is responsible to the County Medical Officer for V.D. prevention and after-care in the administrative county. A confidential clerk-typist in the central office deals with the clerical and statistical work.

The County has been divided into four areas and each social worker traces the contacts, follows up the defaulters and is on the staff of one or more of the special clinics in her area, in order to carry out the clinic social work. Three of the areas are coterminous with the county boroughs of Dewsbury, Doncaster, Halifax and Wakefield and by arrangement three of the social workers undertake similar duties in these county boroughs. This scheme operates smoothly and is a much better one for both patients and medical staff at special clinics than having two social workers at each centre—one for county borough patients and one for administrative county patients.

The social workers have three main duties:—

(1) Social Work. This is carried out mainly in the special clinics where the social worker is able to speak to patients in private and help them with a great variety of problems relating to their disease, their family, their home and their work. No figures are available of the number of patients seen at the clinics but during the year there were 709 interviews with doctors and 1,918 miscellaneous interviews in addition to the work referred to above.

(2) Case Finding. Information about suspected cases of venereal disease is obtained from many sources including new patients known to have the disease. The figures given in Table F relate only to those contacts who were reported as possible cases of venereal disease. Of these contacts 80 per cent. were located and persuaded to attend a clinic for examination.

Table F.

Case finding.

Total number of contacts reported	...	76			
Located and examined	...		61		
Not infected	...			37	
Infected	...			24	
Already under treatment	...				
Brought under treatment	...			24	
Syphilis	...				5
Gonorrhœa	...				7
Other conditions	...				12
Located	...		10		
Not examined	...			5	
Transferred to other authority	...			5	
Not located	...		5		
Insufficient information	...			2	
Unable to locate	...			3	

(3) Case Holding. Known cases of venereal disease may, for a variety of reasons, cease attending before treatment has been completed or tests of cure carried out. In these cases the V.D. social workers communicate with the patients by letter or personal visit, find out the reason for defaulting and help the patients to resume attendance.

The statistics of the work done in this sphere are given in Table G.

Table G.

Defaulters.

Total number of defaulters	Returned to clinic after visiting	Failed to return	Removed, unable to locate	Transferred	Number of ineffective visits	Number of re-visits
267	187	43	10	27	552	572

ANTENATAL CASES:

Pathologists working in the region send to the consultant venereologist the name and address of any doctor (but not the name of the patient) who has sent in for testing a specimen of blood from an antenatal patient giving positive results for syphilis. The venereologist through the V.D. social worker offers assistance to the doctor in arranging the examination and if necessary the treatment of the patient and her contacts. In some cases by this means whole families are examined.

Details of the antenatal cases and their contacts who were investigated by the V.D. social workers are given in Table H.

Table H.

Antenatal patients and contacts.

Patients						Contacts		
Total number reported	No action taken	Number remaining	Found to have Syphilis	Found not to be infected	Transferred to other authorities	Number of contacts examined	Found to have syphilis	Found not to be infected
63	27*	36	17	3	16	18	1	17

* Already on register 18.
False positive 2.
Under care of own general practitioner 7.

It will be seen that at least 17 cases of potential congenital syphilis were prevented from occurring and that a total of 18 new cases with syphilis were found.

Contact Tracing Questionnaire:

During 1962 a questionnaire on contact tracing was sent to the physicians in charge of 205 special clinics in England. The purpose of the enquiry was to find out, what action venereologists take when the contact slip method either cannot be used or fails to bring the contact of a patient with infectious venereal disease under medical examination.

Replies were received from 127 clinics; 98 per cent. take further action to bring the contact under medical examination. More venereologists are in favour of notifying their colleague in the area where the contact resides than the medical officer of health. This latter does not apply in the West Riding, but the findings of this survey were published so that Medical Officers of Health in general shall be aware of the situation.

PART IV

LOCAL HEALTH SERVICES

Care of Mothers and Young Children

Midwifery

Health Visiting

Home Nursing

Ambulance

Health Education

Recuperative Home Treatment

Provision of Nursing Equipment

Laundry Service for Incontinent Patients

Liaison

Chiropody

Domestic Help

Mental Health

CARE OF MOTHERS AND YOUNG CHILDREN

Vital Statistics:							Admin- istrative County	England and Wales
Live Births								
Number	...	...	...	...	...	...	29,792	
Rate per 1,000 population	...	...	...	...	...	...	17·8	18·0
Illegitimate Live Births per cent. of total live births							4·6	
Stillbirths								
Number	...	...	...	...	...	...	561	
Rate per 1,000 total live and still births	...	...	...	...	...	...	18·5	18·1
Total Live and Still Births	...	...	...	...	...	...	30,353	
Infant Deaths (deaths under 1 year)	...	...	...	...	...	...	695	
Infant Mortality Rates								
Total infant deaths per 1,000 total live births	...	...	...	...	...	...	23·3	21·4
Legitimate infant deaths per 1,000 legitimate live births	...	...	...	...	...	...	23·2	
Illegitimate infant deaths per 1,000 illegitimate live births	...	...	...	...	...	...	25·0	
Neonatal Mortality Rate (deaths under 4 weeks per 1,000 total live births)	...	...	...	...	...	...	15·7	15·1
Early Neonatal Mortality Rate (deaths under 1 week per 1,000 total live births)	...	...	...	...	...	...	13·3	
Perinatal Mortality Rate (stillbirths and deaths under 1 week combined per 1,000 total live and still births)	...	...	...	...	...	...	31·5	
Maternal Mortality (including abortion)								
Number of deaths	...	...	...	...	...	...	6	
Rate per 1,000 total live and still births	...	...	...	...	...	...	0·20	0·35

Births:

Registered live births numbered 29,792 compared with 28,553 in the previous year and an annual average of 27,550 in the quinquennium 1957-61. The corresponding crude birth rates were 17·8, 17·2 and 16·8 respectively. Apart from a slight recession in 1959 the rate has increased progressively since 1954 and both the number of births and rate were the highest recorded since 1948. While statistical predictions on the subject are often unreliable the rate of increase of 0·6 per 1,000 population suggests that the peak in the upward trend has not yet been reached.

The practice of relating births to total population, although convenient and conventional, may be misleading. Comparisons of crude rates of single districts or aggregates are not basically valid since no regard is made to the varying age-sex composition of the respective populations. To surmount this difficulty an area comparability factor, which includes an allowance for the proportion of women of child-bearing age in each district population, is applied to the crude

live birth rates. The live birth rates for the past eight years adjusted by the factors applicable for the aggregates of Boroughs and Urban Districts, Rural Districts, the Administrative County, also the national rates, are given below:—

Year	Boroughs and Urban Districts	Rural Districts	Administrative County	England and Wales
1955	14.9	16.8	15.4	15.0
1956	16.0	17.9	16.5	15.7
1957	16.2	17.9	16.7	16.1
1958	16.4	18.0	16.9	16.4
1959	16.2	17.6	16.7	16.5
1960	16.7	17.8	17.1	17.1
1961	16.9	18.5	17.4	17.4
1962	17.7	18.2	17.8	18.0

Accompanying the rise in the number of births and birth rate was an increase in illegitimacy. The number of live births registered as illegitimate was 1,361 or 4.6 per cent. of the total live births. During the inter-war years the proportion was relatively stable around 4 per cent., rising during the last war to a peak of 7.3 per cent. in 1945, thereafter declining to around 3.6 per cent. Since 1959, the proportion has progressively increased and it is distressing that this trend was accentuated and reached the highest recorded since 1948. Reference to the cases dealt with under the Authority's scheme appears on page 105.

The total number of stillbirths registered was 561 equivalent to a rate of 18.5 per 1,000 total births, the lowest total and rate recorded for the Administrative County. There have been slight fluctuations in the rate in recent years and, while the reduction achieved can be viewed with satisfaction, the national rate of 18.1 suggests that further advances are possible. The ratio of illegitimate stillbirths continued at the high level of 5.3 per cent. of the total stillbirths and, although lower than in the previous year (5.9), it compares unfavourably with the corresponding ratio during the period 1957-61 of 5.0.

Infant Mortality:

After the setback reported in 1961 it is satisfactory that the loss of infant life decreased to the second lowest yet recorded. Deaths under 1 year of age numbered 695 equivalent to a rate of 23.3 per 1,000 live births. Compared with the previous year the rate declined by 1.3 per 1,000 live births and was 1.1 lower than the annual average for the period 1957-61 but continues to be higher than the national rate of 21.4.

Minor fluctuations have been recorded in certain years but since the turn of the century the rate has pursued a downward trend as is indicated in the sub-joined table:—

Period	Average Infant Mortality Rate		Year	Infant Mortality Rate	
	England and Wales	Administrative County		England and Wales	Administrative County
1901-1910	128	135	1956	24	27
1911-1920	100	109	1957	23	26
1921-1930	72	80	1958	23	24
1931-1940	59	61	1959	22	24
1941-1945	50	50	1960	22	22
1946-1950	36	40	1961	21	25
1951-1955	27	29	1962	21	23

The relative contribution to the improvement in the past five years by sex and age is indicated in the following table:—

	Number of Deaths					Deaths per 1,000 Live Births				
	1958	1959	1960	1961	1962	1958	1959	1960	1961	1962
<i>Male Infants—</i>										
Under 4 weeks ...	266	256	249	293	297	18.8	18.5	17.3	19.9	19.2
4 weeks—3 months ...	45	67	37	50	42	3.2	4.8	2.6	3.4	2.7
3—6 months ...	43	30	21	38	50	3.0	2.2	1.5	2.6	3.2
6—12 months ...	36	35	27	34	40	2.6	2.5	1.9	2.3	2.6
Total under 1 year ...	390	388	334	415	429	27.6	28.0	23.3	28.3	27.8
<i>Female Infants—</i>										
Under 4 weeks ...	195	183	193	177	170	14.8	13.9	14.2	12.8	11.8
4 weeks—3 months ...	35	32	42	48	26	2.6	2.4	3.1	3.5	1.8
3—6 months ...	30	22	39	30	35	2.3	1.7	2.9	2.2	2.4
6—12 months ...	17	24	20	33	35	1.3	1.8	1.5	2.4	2.4
Total under 1 year ...	277	261	294	288	266	21.0	19.8	21.6	20.8	18.5
<i>All Infants—</i>										
Under 4 weeks ...	461	439	442	470	467	16.9	16.2	15.8	16.5	15.7
4 weeks—3 months ...	80	99	79	98	68	2.9	3.7	2.8	3.4	2.3
3—6 months ...	73	52	60	68	85	2.7	1.9	2.1	2.4	2.9
6—12 months ...	53	59	47	67	75	1.9	2.2	1.7	2.3	2.5
Total under 1 year ...	667	649	628	703	695	24.4	24.0	22.5	24.6	23.3

It will be seen that improvements were recorded at ages under 3 months, especially among females, but these gains were partially offset by the slight increases occurring at higher ages. Male deaths tend to dominate the picture and it is interesting that mortality of males in the neonatal period exceeded that of total females under 1 year.

Of the infant deaths 467 or 67 per cent. occurred within 28 days of birth; the resultant neonatal death rate was 15.7 per 1,000 live births which is the lowest recorded. The subjoined table indicates the number of deaths and death rates at various ages in the neonatal period.

	Number of Deaths							Deaths per 1,000 Live Births						
	1956	1957	1958	1959	1960	1961	1962	1956	1957	1958	1959	1960	1961	1962
Under 1 day ...	235	237	216	211	227	238	235	8.9	8.8	7.9	7.8	8.1	8.3	7.9
1—7 days ...	210	200	175	157	157	170	160	7.9	7.4	6.4	5.8	5.6	6.0	5.4
1—4 weeks ...	76	72	70	71	58	62	72	2.9	2.7	2.6	2.6	2.1	2.2	2.4
Total under 4 weeks	521	509	461	439	442	470	467	19.7	18.9	16.9	16.2	15.8	16.5	15.7

The number of deaths in the first day of life was again higher than in the remainder of the neonatal period while deaths under 1 week contributed 85 per cent. of the neonatal and 57 per cent. of the total infant mortality. The distribution of the infant deaths assigned to the groups of diseases comprising the International Short List appears on page 29 but to gain a clearer appreciation of the contributory causes a detailed analysis is appended:—

Ætiological Group	Cause of Death (and International Classification number)	Age at Death						
		Under 1 day	1 day and under 1 week	1 week and under 1 month	1 month and under 3 months	3 months and under 6 months	6 months and under 1 year	Total under 1 year
ALL CAUSES	All Causes	235	160	72	68	85	75	695
Prenatal and Natal Group (including congenital malformations)	Congenital malformations (750-759)	35	39	28	16	18	12	148
	Total causes mainly of prenatal and congenital malformations	195	109	14	—	1	—	319
	Immaturity alone, or primary to diseases other than of early infancy (774, 776) ...	87	40	5	—	—	—	132
	Attributed to maternal toxæmia (769)	6	4	1	—	—	—	11
	Ill defined diseases of early infancy (773)	3	4	—	—	—	—	7
Postnatal Group	Postnatal asphyxia and atelectasis (762)	67	36	2	—	1	—	106
	Intracranial and spinal injury at birth (760)	17	19	5	—	—	—	41
	Other birth injury (761)	2	1	—	—	—	—	3
	Erythroblastosis (770)	13	2	1	—	—	—	16
	Hæmorrhagic disease of newborn (771)... ..	—	3	—	—	—	—	3
	Total causes mainly of postnatal origin	1	6	26	49	61	53	196
	Gastro-enteritis (including diarrhœa of newborn) (571, 764)	—	—	2	4	6	10	22
	Pneumonia and bronchitis (490-493, 763, 500-502)	1	6	18	37	36	26	124
	Other diseases of respiratory system (470-475, 510-527)	—	—	—	—	1	4	5
	Causes classified as infective (001-138): others mainly infective in origin (340, 391-393, 480-483)	—	—	5	5	10	7	27
Whooping cough and Measles (056, 085)	—	—	—	1	—	1	2	
Influenza (480-483)	—	—	—	—	—	2	2	
Otitis media and mastoiditis (391-393)	—	—	1	—	3	—	4	
Septicæmia (053)	—	—	—	1	4	1	6	
Meningococcal infections and non-meningococcal meningitis (057, 340)	—	—	3	2	3	2	10	
Causes classified as infective not mentioned above (remainder 001-138)	—	—	1	1	—	1	3	
Accidental mechanical suffocation from vomit, food, foreign body, or in cot (E921-E925)	—	—	1	3	6	6	16	
Infanticide (E980-E985)	—	—	—	—	1	—	1	
Other violent causes (remainder E800-E999)	—	—	—	—	1	—	1	
Unclassified	Other remaining causes	4	6	4	3	5	10	32

Of the 395 deaths in the first week of life 96 per cent. were due to conditions present before, or during birth. In descending order the major causes of death at these ages were immaturity 127 (32 per cent. of the total deaths under 1 week), postnatal asphyxia and atelectasis 103 (26 per cent.), congenital malformations 74 (19 per cent.) and birth injuries 39 (10 per cent.).

At ages one week up to one year the more predominant causes of the 300 deaths were pneumonia and bronchitis 117 (39 per cent. of the total deaths at these ages), congenital malformations 74 (25 per cent.), infective diseases 27 (9 per cent.) and gastro-enteritis 22 (7 per cent.).

Perinatal Mortality:

The term perinatal mortality describes the combination of stillbirths and deaths in the first week of life which provides an indication of the loss of infant life due to conditions associated with pregnancy and events during labour and delivery. The mortality rate is expressed per 1,000 total births and the following table gives the perinatal mortality rate also the death rate of infants aged one week up to one year for the past 11 years:—

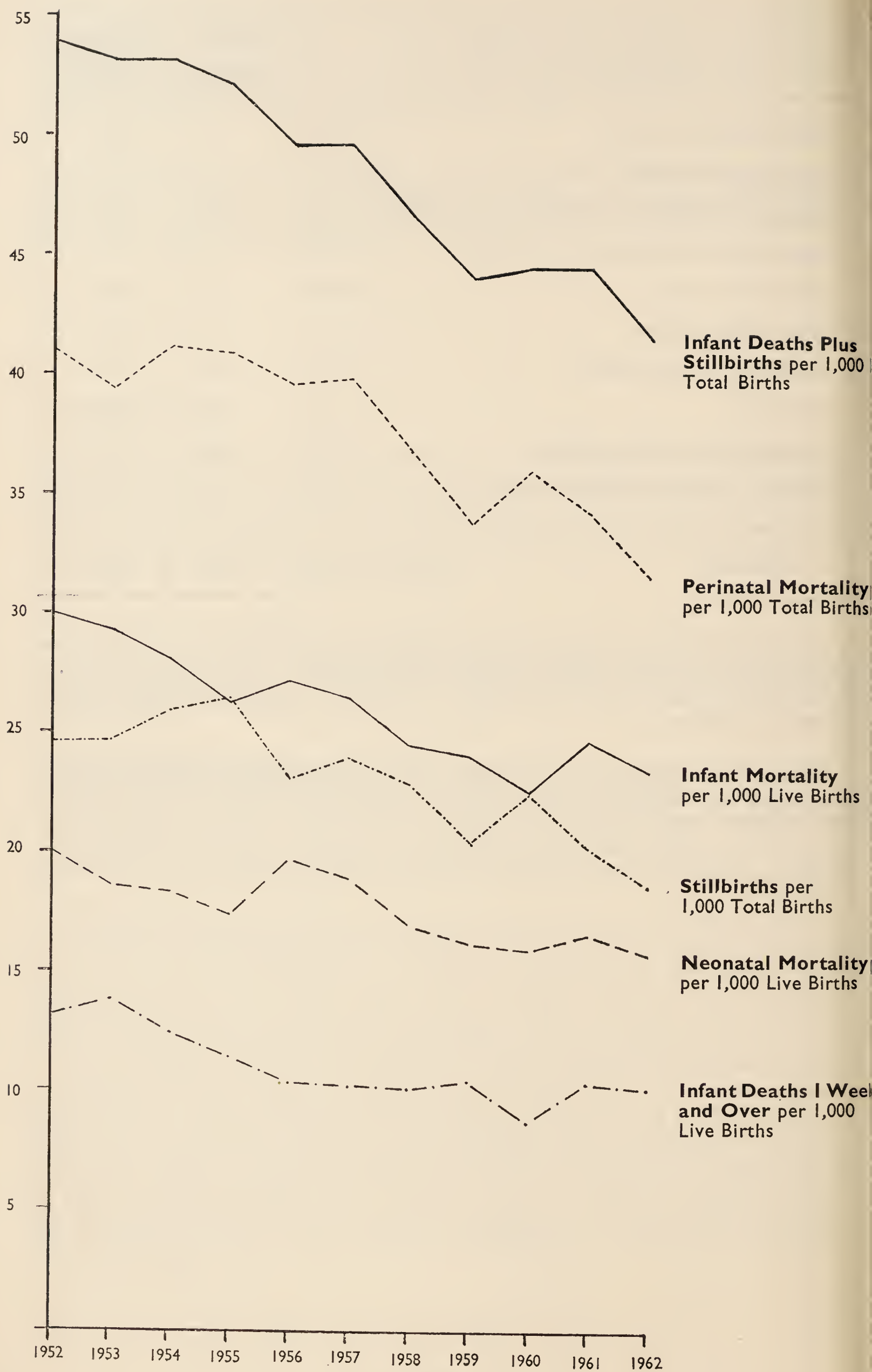
	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962
Perinatal mortality (per 1,000 total births)	41·0	39·8	41·1	40·8	39·5	39·7	36·7	33·7	35·9	34·2	31·5
Infant deaths at 1 week and over (per 1,000 total births)	12·9	13·4	12·1	11·1	10·1	9·9	9·9	10·2	8·5	10·1	9·9

Minor fluctuations have been evident in recent years and it is gratifying that for the third successive year the rate progressively declined; in 1962 the record low level of 31·5 was registered. As referred to previously, the major contributions to deaths in the first week of life were immaturity, postnatal asphyxia and atelectasis, and congenital malformations. Many of these infants lived but a few hours and 63 per cent. of the deaths at these ages had a birth weight of 5½ lb. or less. Our present state of knowledge has many gaps and continued research is essential before significant reductions can be achieved. The Population (Statistics) Act, 1960, which requires medical practitioners, or in their absence, midwives, to record the cause of each stillbirth they attend, the estimated duration of pregnancy, and the weight of the foetus, if known, is providing useful information which, together with other information obtained at registration of the birth, should contribute materially in studies on this and allied subjects. The following table gives the number of stillbirths by cause and the rate per 1,000 total births.

Cause and I.C.D. number	Number of stillbirths	Rate per 1,000 total births
Chronic disease in mother (Y 30)	7	0·23
Acute disease in mother (Y 31)	—	—
Diseases and conditions of pregnancy and childbirth (Y 32)	128	4·22
Absorption of toxic substance from mother ... (Y 33)	—	—
Difficulties in labour... .. (Y 34)	32	1·05
Other causes in mother (Y 35)	2	0·07
Placental and cord conditions (Y 36)	120	3·95
Birth injury (Y 37)	8	0·26
Congenital malformation of foetus (Y 38)	114	3·76
Diseases of foetus and ill-defined causes (Y 39)	150	4·94
All causes (Y 30—Y 39)	561	18·48

At ages one week up to one year the death rate continued at a relatively low level, a rate of 9·9 per 1,000 total births being recorded. Slight fluctuations are to be expected and further permanent reductions, although possible, will be difficult to achieve.

Illustrated graphically are the trends of the rates associated with loss of foetal and infant life during the past 11 years. It will be seen that the total wastage, i.e., stillbirths plus deaths in the first year of life, has decreased progressively from 53·9 per 1,000 total births in 1952 to 41·4 in 1962. Except for infant deaths at ages one week up to one year all the rates in 1962 were the lowest yet recorded.



Maternal Mortality:

The number of deaths decreased further to yet another record low level. Only 6 deaths were registered—three from sepsis, one toxæmia, one other complications and one septic abortion—compared with 8 in the previous year and an annual average of 13 in the quinquennium 1957-61. The equivalent death rates per 1,000 total births were 0·20, 0·27 and 0·46 respectively.

The table appended affords a comparison of the national and county death rates from various causes in the past five years.

Cause of Death	1958		1959		1960		1961		1962	
	Admin. County	England and Wales	Admin. County	England and Wales	Admin. County	England and Wales	Admin. County	England and Wales	Admin. County	England and Wales
Maternal sepsis (not associated with abortion) ...	0·04	0·07	0·04	0·06	0·14	0·04	—	0·04	0·10	0·28
Toxæmias of pregnancy and puerperium (not associated with abortion) ...	0·14	0·09	0·14	0·07	0·10	0·08	0·07	0·07	0·03	
Other complications of pregnancy, childbirth and the puerperium ...	0·18	0·19	0·18	0·18	0·31	0·19	0·21	0·16	0·03	
Abortion (with or without mention of sepsis or toxæmia) ...	0·07	0·08	—	0·06	0·17	0·08	—	0·07	0·03	0·07
Total Maternal Mortality...	0·43	0·43	0·36	0·38	0·73	0·39	0·27	0·33	0·20	0·35

Ante and Post Natal Services:

There were 149 ante and post natal clinics in operation at the end of the year, and the number of women who attended, prior to confinement, was 11,119, of which 8,927 were new cases. The total attendances were 35,003 at doctors' sessions and 26,332 at midwives' sessions only, the latter figure including attendances at relaxation classes.

Post natal attendances continue to be low; 1,099 women attended compared with 1,234 in 1961 and 1,169 in 1960.

Dental Treatment of Expectant and Nursing Mothers and Pre-School Children:

The Chief Dental Officer reports:—

The National Health Service Act, 1961, exempted expectant and nursing mothers from charges for dentures obtained from general dental practitioners in the National Health Service.

This removed a disparity between the general dental service and the local authority dental service, where there was never a charge for denture work. Nineteen hundred and sixty-two is the first complete year worked since the Act effected this change which has great significance for the local authority service.

In those areas where a staffed dental clinic is in existence work for the priority classes has been done by the County Dental Officer. A number of patients have attended the clinic only because dentures could be obtained free of charge, and this class of patient no longer attends as private practitioners can now provide a free prosthetic service. Many dental officers, however, have built up a priority service which is of good reputation as providing excellent dentistry of all kinds and these areas have not suffered any decrease in attendances. A total of 777 expectant and nursing mothers were treated by County Dental Officers compared with 863 in 1961.

Where it had not proved possible to appoint Dental Officers the priority classes were referred to general practitioners who provided treatment in their own surgeries, being recompensed by the County Council with fees equivalent to those payable under the General Dental Service Regulations. This service has been reduced by almost two-thirds. There being no advantage to dentist or patient in using the County's service it seems that the dentists are treating these patients under the General Dental Service.

Had it not been for the change under the 1961 Act, the improved staffing position in 1962 would have effected an increase in the treatment provided for the priority classes. As staffing in some areas is now up to strength it will be possible to make an attempt to build up the priority service. This service has never developed to any great extent as demand has never been large, whereas in the School Dental Service demand has been too much for the service's resources. A deliberate increase made in the one service could only have been at the expense of the other. As staffing improves the real demand for this service will become more apparent and appropriate measures can be taken to meet it.

				By County Dentists	By Private Practitioners	Total
Number of cases referred	...	...	...	912	701	1,613
Number of cases examined	...	...	...	856	516	1,372
Number of cases found to require treatment				850	500	1,350
Number treated	...	...	...	777	447	1,224
Number made dentally fit	...	...	...	704	390	1,094
Number of extractions	...	...	...	3,515	3,103	6,618
Number of fillings	...	...	...	1,222	527	1,749
Number of general anæsthetics	...	...	...	367	241	608
Number of scalings	...	...	...	371	147	518
Number of complete dentures	...	...	...	609	392	1,001
Number of partial dentures	...	...	...	193	116	309
Number of X-rays	...	...	...	73	7	80
Number of crowns/inlays	...	...	...	13	5	18
Number of root treatments	...	...	...	3	0	3
Number of cases treated with Silver Nitrate				0	0	0

The following work has been carried out during the year for pre-school children by School Dental Officers —

Number inspected	...	...	...	...	1,161
Number treated	...	...	...	...	1,064
Number of attendances	...	...	...	...	1,380
Number of extractions	...	...	...	...	1,682
Number of general anæsthetics	...	...	...	...	723
Number of teeth filled	...	...	...	...	457

Number of fillings	...	...	...	...	488
Number of teeth treated with silver nitrate	...				98
Number of dressings	...	...	...	...	26
Number of scalings	...	...	...	...	0
Number of X-rays	...	...	...	...	6
Number of gum treatments	...	...	...	...	0

Infant Welfare:

At the end of the year, there were 231 static and 3 mobile clinics in operation, at which 529,691 attendances were made—an increase of 22,910 over the previous year. The main increase (20,601) was in respect of children under one year of age. An analysis of the total attendances shows that 90 per cent. of the age group “under one year”, 68 per cent. of the age group “one year but under two years”, and 19 per cent. of the age group “two years but under five years” attended centres during the year.

There was further progress during the year in the provision of new clinics, eight clinics being completed at Wath upon Dearne, South Kirkby, Carcroft, Askern, Darfield, Royston, Outwood and Springhead. This brings the total of new clinics erected since 1955 to 33. Eight additional clinics at Goldthorpe, Guiseley, Cudworth, Baildon, Birdwell, Otley, Wickersley and Thurcroft were in the course of erection at the end of the year or contracts for their erection had been approved. The programme for 1963/4 and 1964/5 provides for further clinics at Thorne, Brighouse, Skipton, Stocksbridge, Kilnhurst, Conisbrough, Uppermill, Scissett, Garforth, Mexborough, Hoyland and Holmfirth.

Towards the end of the year, a Special Sub-Committee—appointed to review once again existing rented clinic premises—began a series of meetings. The object of this review is two-fold: first to determine those premises which can be improved to remove certain unsatisfactory features, and secondly to determine whether certain clinics can be closed down by erecting new clinics of a small type to serve areas of low population, such clinics to be used for a variety of health and welfare services including, where possible, use by general practitioners. This project is referred to in greater detail in that section of the Report dealing with the Authority’s Ten-Year Development Plan.

As part of their arrangements for infant welfare, the County Council continue to have available to them the services of Dr. Harvey, the County Pædiatrician, who reports as follows:—

Perinatal Mortality:

The results of analysis of the 1958 National Birthday Trust Survey are now coming through in instalments.

The importance of the danger of post-maturity is emphasised. A mother, who goes three weeks overdue, doubles the risk of losing her baby. The preventive study of perinatal deaths should point also to the recognition of “NEAR” deaths, i.e., surviving children whom the hazards of birth have just failed to kill, but have left with irretrievable damage. Babies, who at birth are discrepantly “small-for-dates”, include a group with high-mortality hazard, due to defects in their nutrition before birth, but others of these small babies at full term have evidently inherited from their parents a normal tiny physique.

Deafness Diagnostic Clinics:

This year surely has proved the importance of these new clinics. The rush of doubtful cases may, however, endanger the speed of clinching the diagnosis in infants whose need of hearing aids is critically more urgent than that of any school child.

This year a toddler, with the rare nerve deafness secondary to meningococcal meningitis, lost valuable diagnostic time through mother’s missing clinic appointments and then a spell in hospital with nephritis.

Developmental Diagnosis Clinics:

In several divisions, I have held more frequent sessions for leisurely follow-up of suspected retardation problems, in which it is often possible to anticipate questions for the school medical officer in the future. Sometimes, better still, suspicion can be cleared away once for all. A particularly gratifying instance was a five-year follow-up of a severe virus encephalitis in babyhood with a fortnight's convulsions. This boy's scoring at 5½ years now gives good promise of a grammar school future.

Tongue Tie:

Though disproved as a significant cause of speech defects, it has now been suggested as a cause of decay of back teeth, through inability of the tongue tip to search for and remove food debris.

Ian, aged three, was admitted to hospital to give the neighbours respite from his nocturnal head-banging. Mother complained that, because the doctors would not cut his tongue when he was a baby, he has now been driven to cursing and swearing by reason of his inability to put his tongue out to provoke his brother. Tongue clipping as a prophylaxis for profanity would, however, be carrying purity of expression too far.

Poisoning in Young Children:

This is the most common MEDICAL emergency in toddlers. Almost every week we admit such problems to hospital, some of which only just fail to be fatal, and a tragic few succeed. Iron tablets, aspirin, bedwetting tablets and sleeping tablets all raise serious dangers. It passes comprehension what vile-tasting liquids toddlers will drink out of old lemonade bottles left on the floor, such as car-polish and crude disinfectants. An American expert advises that adults should never make a game of giving drugs to children and should never bribe children by describing drugs as CANDY. Adults should take their own drugs in private, so as not to put ideas into children's heads.

A toddler recently grabbed and drank some industrial nitrite oil his father was using, and was admitted dangerously ill and deeply blue with his blood hæmoglobin converted to methæmoglobin. Fortunately, a prompt injection of methylene blue, at the ready in the ward poison kit, was able to restore his normal pink colour and health in minutes.

Phenylketonuria:

Health visitors have continued, during 1962, to test the urine of as many babies as possible during the fourth week of life by the 'Phenistix' test. During the year, 28,052 babies were tested.

Since the beginning of the scheme in March, 1960, the following results have been obtained.

Total number of children tested March, 1960, to 31st December, 1962 76,251

Ratio of true cases of phenylketonuria to children tested 1:12,708

Details of the cases are given in the table below:—

Initials	Date of Birth	Age in weeks when urine tested		Who found positive result
		Negative result obtained	Positive result obtained	
(a) <i>Positive urine results obtained in the field (and confirmed positive by the laboratory) but child became negative soon after and did not need dieting</i>				
C.J.	15-12-60	—	4	Health Visitor
P.G.	15- 6-61	—	4	Health Visitor
J.H.	21- 8-61	—	3	Health Visitor
A.B.	18- 4-62	—	6	Health Visitor

(b) *Positive urine results obtained (and confirmed by laboratory blood tests) and child regarded as a case of PK. requiring diet*

C.C.	9-10-60	—	8	Health Visitor
P.M.	9- 1-61	6	83	G.P./Specialist
		(Health Visitor)		
R.W.	6- 2-61	3	78	G.P.
		(Health Visitor)		
I.W.	19- 9-61	5	19	G.P./Specialist
		(Health Visitor)		
M.A.W.	20- 2-62	—	7	Health Visitor
S.P.I.	30- 7-62	—	4	Health Visitor

(c) *Positive urine result obtained in the field, not subsequently confirmed in the laboratory*

M.S.S.	17-10-61	—	3	Health Visitor
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With the known low incidence of phenylketonuria, it is inevitable that some may doubt whether the large efforts made by staff in the detection of the disease are justified, but the alternative is to condemn needlessly a number of children to permanent mental handicap. In the West Riding, we intend to proceed with routine testing.

Dietary treatment of the six known cases has proved possible and reports on those of the children still in the administrative area, with one exception (S.P.I. whose phenylketonuric condition remains unstable), are of apparently normal rates of physical and mental development.

The proportion of false positives in “Phenistix” testing is of interest but, to those engaged in screening, the false negative is the danger to be avoided and testing techniques need constant emphasis. Since the beginning of the testing, as shown in the above table, three of our six known cases of phenylketonuria presented as false negatives on testing routinely by health visitors. These cases were discovered by later positive test results obtained by general practitioners. Some part of this can be attributed to the fact that variations in protein intake and enzyme activity take place, and blood amino acid levels may vary widely at different times in some cases.

Ortolani Test for Congenital Dislocation of the Hip:

Simultaneous publications by T. G. Barlow (Hope Hospital, Salford) and S. Van Rosen (Malmo, Sweden) have directed attention to the valuable contribution the Public Health Service can make to the satisfactory treatment of this condition.

In a newborn baby, the hip joint consists of a shallow cavity on each side of the pelvis, into which the head of the thigh bone is held by the “wrapping” of tissues known as the capsule of the joint. On the tightness of this capsule at birth and soon afterwards, depends whether the hip joint is held together firmly and develops normally. When the capsule is slack, the head of the thigh bone can rest outside the joint cavity, in the dislocated position, and if untreated, remains there to give trouble later. If treatment is delayed beyond the age of six months, operations and prolonged immobility in splints will not always result in restoration of normal anatomy and function of the joint.

The incidence of dislocation of the hip is believed to be about two per thousand children born.

It is now known that:—

1. If the condition is diagnosed and treated before the age of two months, the treatment lasts only 3—4 months, and may be carried out at home with only weekly check visits to hospital. The cure is complete after this period.
2. A simple test known as the Ortolani Test can be used to detect the condition immediately after birth and thereafter.

From 3rd December, 1962, domiciliary midwives, health visitors and clinic doctors are to perform the Ortolani Test on every baby coming into their hands for the first time. They will inform the child's General Practitioner and the Divisional Medical Officer whenever the test is positive, and the latter will advise immediate referral to an Orthopædic Surgeon.

By this means it is hoped that every case will be caught at the stage when complete cure is possible without the years of splinting and repeated operations to which some children have been subjected in the past.

Amblyopia:

In the course of normal development, an infant learns to focus both eyes simultaneously on an object at about the age of six months and, with practice, develops reflexes which make him expert at fixing both eyes on every object at which he looks.

However, in some children (about 5 per cent. of all infants), this skill is never learned, and one eye only continues to do the major part of the work, the other eye becoming lazy. This condition of "lazy eye" is called amblyopia and, in a young child, progresses in a very short time to irreversible blindness in that eye if untreated.

This problem has been reviewed during the year and a study made of the means available to ensure treatment of the condition in time to prevent blindness. Clinic doctors and health visitors have been re-instructed in the techniques and need for early diagnosis, and agreement has been obtained with general practitioners for elimination of delay in the referral of infants and toddlers to eye specialists. In future, any children over the age of six months, who are suspected by our staff to be developing amblyopia, are to be referred directly to the specialist for treatment. Every attempt will be made to persuade parents to co-operate fully in saving the eyesight of their children throughout what is usually a long period of supervision by Orthoptists working in the hospital service.

Welfare Foods:

The arrangements for the distribution of welfare foods from Child Welfare Centres, Divisional Health Offices, and, to a lesser extent, by private householders and the retail trade, have continued during the year. The following table shows the extent of the distribution of welfare foods during 1962 and also for comparative purposes, for the year 1961.

Period	National Dried Milk (Tins)		Cod Liver Oil (Bottles)		Vitamin A & D Tablets (Packets)		Orange Juice (Bottles)	
	1961	1962	1961	1962	1961	1962	1961	1962
January-March	41,341	35,098	30,572	8,895	19,537	8,716	168,455	52,654
April-June ...	37,632	34,346	19,844	7,034	16,361	7,640	127,752	64,411
July-September	35,755	33,663	5,506	6,974	7,069	7,651	47,722	68,782
October-December	35,891	32,473	7,882	8,605	7,958	7,579	47,880	62,088
Totals	150,619	135,580	63,804	31,508	50,925	31,586	391,809	247,935

At 31st December, 1962 there were 316 distribution centres in the County for the issue of welfare foods, of which 228 were Child Welfare Centres.

Illegitimate Children:

Of the total of 1,361 live illegitimate births, 1,007 were dealt with as indicated in the table below; 958 of them were of West Riding domicile, the remaining 49 being non-County cases. Of the County cases, 204 were accommodated during the ante or post natal period in moral welfare homes under the scheme of the authority.

				West Riding Cases	Non- County Cases	Total
Number of cases dealt with during the year:						
Referred by Moral Welfare Organisations	...			183	31	214
Ascertained by Staff of the Health Department				537	6	543
Referred by other services	...	...	...	238	12	250
				—	—	—
	Totals	...	...	958	49	1007
				—	—	—
Analysis of cases:						
Married	{	with previous illegitimate children		103	2	105
	{	without previous illegitimate children		133	2	135
Unmarried	{	with previous illegitimate children	...	125	2	127
	{	without previous illegitimate children		538	42	580
Widowed	{	with previous illegitimate children	...	25	—	25
or Divorced	{	without previous illegitimate children		34	1	35
				—	—	—
	Totals	...	...	958	49	1007
				—	—	—

Ages:

Under 15 years of age	...	...	...	...	2	1	3
15—19 years of age	...	...	...	...	295	18	313
20—24 years of age	...	...	...	...	277	15	292
25—29 years of age	...	...	...	...	186	8	194
30—39 years of age	...	...	...	...	168	7	175
40 years of age and over	...	...	...	...	30	—	30
					—	—	—
Totals	...	...	...	...	958	49	1007
					—	—	—

Disposal:

Cases settled—Marriage	...	...	...	...	48	1	49
Baby died	...	...	...	...	26	—	26
Grandparents taking baby	...	...	...	...	36	1	37
Baby adopted	...	...	...	...	149	24	173
Baby fostered	...	...	...	...	21	4	25
Mother keeping baby	...	...	...	...	639	17	656
Cases referred elsewhere	...	...	...	...	6	2	8
Cases not finally settled	...	...	...	...	33	—	33
					—	—	—
Totals	...	...	...	...	958	49	1007
					—	—	—

Accommodation was provided for the 204 cases in moral welfare homes as outlined below:—

	Ante and Post natal	Ante natal only	Post natal only	Governing Body
Bradford—Oakwell House	6	1	2	Bradford Corporation
Bradford—St. Monica's Home	20	5	—	Church of England
Birmingham—Catholic Maternity Home	1	—	—	Roman Catholic Church
Cambridge—Ely Diocesan Home	1	—	—	Church of England
Chester—St. Bridget's Home	1	—	—	Church of England
Gateshead—St. Faith's Hostel	1	—	—	Church of England
Halifax—St. Margaret's House	19	2	—	Church of England
Harrogate—St. Monica's Home	13	—	—	Church of England
Huddersfield—Queen Street Mission	2	—	1	Methodist Church
Huddersfield—St. Katharine's Hostel	9	1	—	Church of England
Kendal—St. Monica's Maternity Home	2	—	—	Church of England
Lancaster—Girls' Hostel	1	—	—	Church of England
Leeds—Browning House	21	—	—	Voluntary Committee
Leeds—Mount Cross, Bramley...	13	1	—	Salvation Army
Leeds—St. Margaret's Home	17	—	1	Roman Catholic Church
Lincoln—The Quarry Maternity Home	10	—	—	Church of England
Liverpool—St. Monica's Home...	1	—	—	Church of England
Manchester—Methodist Maternity Home	1	—	—	Methodist Church
Manchester—St. Agnes' House...	1	—	—	Church of England
Newcastle—Hopedene	2	—	—	Salvation Army
Pontefract—"The Haven"	6	—	1	Church of England
Sheffield—St. Agatha's Hostel	22	1	—	Church of England
Sutton-on-Hull—Sutton House	2	1	—	Church of England
York—Heworth Moor House	14	1	—	Church of England
	186	13	5	

Premature Infants:

According to a nationally agreed definition a premature infant is one which weighs $5\frac{1}{2}$ lb. or less at birth, irrespective of the length of gestation. There were 2,218 premature births, of which 1,925 were live and 293 still. Of the premature live births, 20 per cent. were born at home and 78 per cent. in hospitals. Of those born at home, 83 per cent. weighed more than 4 lb.

THE FATE OF PREMATURE BABIES BORN IN THE YEAR 1962 TO MOTHERS NORMALLY RESIDENT IN THE WEST RIDING
ADMINISTRATIVE COUNTY AREA WHEREVER THE BIRTH TOOK PLACE

Total adjusted live births—29,792

Number of live premature births—1,925

Percentage of premature live births to total live births—6.5

Number born dead—293

Weight Group lb.	Number of Premature Births					Number Dying														Number Surviving over 28 days					Percentage Survival 1962	Percentage Survival in previous years					
	Born Alive				Total Deaths	First Week							Second Week							Over 14 up to 28 days	A	B1	B2	C	Total	1961	1960	1959	1958	1957	
	A	B1	B2	C		Total	1	2	3	4	5	6	7	8	9	10	11	12	13												14
5—5½	168	13	265	332	778	28	10	1	—	1	1	1	1	1	—	—	—	—	1	1	165	12	258	320	755	97.0	95.4	97.2	96.4	95.7	96.0
4½—5	113	8	144	193	458	36	18	4	—	2	—	—	—	—	—	—	—	—	—	—	108	7	137	179	431	94.1	92.1	94.8	92.9	92.9	92.1
4—4½	43	—	90	123	256	33	10	6	—	1	2	—	—	—	—	1	1	—	—	—	41	—	77	110	228	89.1	90.3	88.7	86.9	89.9	85.7
3½—4	32	3	41	84	160	36	11	6	2	—	—	1	—	—	—	—	—	—	—	30	3	35	69	137	85.6	77.1	84.1	84.8	79.3	81.0	
3—3½	15	1	24	63	103	46	21	3	2	—	—	—	—	—	—	1	1	—	—	10	1	14	44	69	67.0	68.2	72.6	60.9	65.9	54.8	
2½—3	8	—	22	31	61	32	22	4	2	1	—	—	—	1	—	—	—	—	—	4	—	9	12	25	41.0	39.3	44.3	40.4	40.9	39.4	
2—2½	7	1	12	27	47	42	20	5	—	2	—	1	—	—	1	—	—	—	1	4	1	3	6	14	29.8	19.4	43.9	27.9	26.1	20.0	
1½—2	3	—	8	20	31	27	24	2	2	—	—	1	—	—	—	—	—	—	—	—	—	—	1	1	3.2	15.2	2.3	4.2	10.9	9.8	
1½ and under	2	—	3	26	31	13	25	2	2	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3.0	—	—	—	—	
Total	391	26	609	899	1925	293	164	33	26	10	8	3	4	1	2	1	2	2	1	2	362	24	533	741	1,660	86.2	84.6	87.1	84.7	84.7	83.3

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11

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The weight groups in the first column of this table should be read as under :—

“ 5—5½ lb.” means “ Over 5 lb. up to and including 5½ lb.”

“ 4½—5 lb.” means “ Over 4½ lb. up to and including 5 lb.”

The remaining weight groups should be read in the same way.

A —Born in Domiciliary Practice.

B1—Born in Private Nursing Home.

B2—Born in Maternity Home.

C —Born in General Hospital.

Children Neglected or Ill-treated in their Own Homes—Prevention of Break-up of Families:

Throughout the Administrative County, there were 92 formal meetings of the Co-ordinating Committees established under the Chairmanship of the Divisional Medical Officer for the area to co-ordinate the activities of the many statutory and voluntary organisations concerned in the welfare of children. In 11 Divisions meetings were held quarterly or at more frequent intervals and, in 9 Divisions, meetings were held less frequently than quarterly. No formal meetings were held in the remaining 3 Divisions but there was consultation between officers as the need arose in dealing with individual cases.

The Co-ordinating Committees include in their membership officers of the local health and education authorities concerned with children, representatives of the housing authorities and representatives of the various voluntary agencies. The co-ordination of these resources can give valuable assistance with problem families to prevent their break-up and, although in many cases little or no improvement is achieved, further deterioration may be prevented.

The arrangements, made by the County Council following the issue of the Joint Circular of the Ministry of Housing and Local Government (17/59) and the Ministry of Health (4/59) and after consultation with the housing authorities, to safeguard the interests of housing authorities in selected cases where there was a danger of the families being evicted, broken-up and the children being taken into care have continued.

During the year, the Special Sub-Committee considered the cases of 101 families in which applications for assistance had been made by housing authorities. The total number of children involved was 513.

In general, it is felt that the arrangements are proving well worthwhile, a view expressed by Dr. Hunter, Divisional Medical Officer (Skipton), who writes:—

“With regard to the assessment of results achieved where the County Council have assisted a housing authority, this scheme is proving valuable and is very welcome in that it represents an entirely different approach. Obviously it does not show spectacular results, but it has undoubtedly prevented the eviction and perhaps the prosecution of a number of parents—measures which have achieved nothing in the past.”

Dr. Barnes, Divisional Medical Officer (Barnsley), considers that the one outstanding trend in the work of the Co-ordinating Committees during the year was the increasing part played by housing managers at the meetings. It is his impression that these officers have received from the meetings a more balanced view of some of the problems affecting their tenants.

The value of meetings of the Co-ordinating Committees to the officers concerned is frequently mentioned by Divisional Medical Officers. Dr. Appleton (Goole), reports:—

“Probably the greatest value is the exchange of information and views which can be quite divergent according to the departmental eyes through which the problem is seen.”

Much useful work continues to be done by co-operation between officers of the various authorities outside the formal meetings of the Committees. Dr. Appleton, Divisional Medical Officer (Brighouse), reports:—

“When a case has to be dealt with, it is often a matter of great urgency and cannot wait until a meeting of the Committee can be called. Our relationship with the Children's Officer, with the Probation Officer, with the National Assistance Officer and with the N.S.P.C.C. Inspector is very good indeed.”

Dr. Burn, Divisional Medical Officer (Horsforth), considers that the types of case dealt with may be divided into the following two main divisions:—

“ 1. The ‘ hard case ’ which stems from fundamental inadequacy in one or both parents. These cases are always with us and in some the most that can be done is to remedy the difficulties as they arise, with special reference to the well-being of the children,

and

2. The case where parents give way under the stress of some specific difficulty, financial or social, with which they cannot contend. Assistance in overcoming the particular difficulty can often provide a solution, but the family which manifests this kind of reaction in the face of adversity is kept in sight for fear of future difficulties.”

Day Nurseries:

There are five day nurseries in operation, which provide more than adequate accommodation to meet the established need, for reasons of health and associated socio-medical conditions, of the areas in which they are situated. The County Council's policy is to admit only the following categories:—

- (a) The young child whose mother is ill or having a baby.
- (b) The illegitimate child whose mother is required to work.
- (c) The young child of the widow who must educate and support her family unassisted.
- (d) The young child of the mother whose husband is ill.

Details of places provided and attendances are given in the following table:—

<i>Division Number</i>	<i>Day Nursery</i>	<i>Number of Places Provided</i>	<i>Average Daily Attendance</i>
3	Keighley	50	34
4	Shipley	50	33
7	Harrogate	40	25
15	Heckmondwike	40	30
18	Brighouse	40	19

The situation has remained under periodic review by the Day Nurseries Sub-Committee.

With effect from 1st September, all five day nurseries were re-classified as training nurseries so as to provide practical training facilities for students resident in the West Riding, who have been accepted on courses for student nursery nurses organised by the County Boroughs of Leeds, Bradford and Sheffield.

Financial responsibility was accepted for the accommodation of five children in day nurseries administered by the County Boroughs of Huddersfield and Sheffield, and, at the end of the year, four children were in attendance at day nurseries administered by these two County Boroughs.

MIDWIFERY

Institutional Midwifery:

Hospital accommodation was provided for 63 per cent. of the total births, the same percentage as for 1961. However, this figure is misleading for, in that part of the County within the administrative control of the Leeds Regional Hospital Board, the percentage was 70 while, in the Sheffield Board area, the percentage was as low as 50. The inequity in the distribution of lying-in beds is illustrated in the following table.

Div. No.	Area	Population (estimated mid 1962)	Total Births (Live and Still)	Place of Birth			
				Hospital		Domiciliary	
				No.	%	No.	%
1	Skipton	79,840	1,212	1,009	83	203	17
3	Keighley	56,070	1,043	917	88	126	12
4	Shipley	67,830	1,153	903	78	250	22
5	Horsforth	116,630	2,012	1,628	81	384	19
7	Harrogate/Ripon	105,820	1,628	1 317	81	311	19
9	Wetherby	51,260	793	475	60	318	40
10	Goole	44,600	802	384	48	418	52
11	Castleford	58,930	1,052	675	64	377	36
12	Pontefract	62,250	1,201	684	57	517	43
13	Morley	86,250	1,599	988	62	611	38
15	Batley	48,410	897	748	83	149	17
16	Rothwell	58,630	1,023	525	51	498	49
17	Spenborough	49,970	854	707	83	147	17
18	Brighouse	58,950	1,047	708	68	339	32
19	Todmorden	52,680	871	487	56	384	44
20	Colne Valley	90,280	1,394	1,065	76	329	24
22	Wortley	91,480	1,508	1,008	67	500	33
23	Hemsworth	66,930	1,372	716	52	656	48
25	Barnsley	76,900	1,376	742	54	634	46
26	Wath/Mexborough	109,920	2,094	907	43	1,187	57
27	Doncaster/Adwick	112,860	2,434	1,137	47	1,297	53
29	Thorne	35,760	812	375	46	437	54
31	Rotherham	95,010	1,953	940	48	1,013	52
Leeds Hospital Board Region ...		1,155,330	19,953	13,936	70	6,017	30
Sheffield Hospital Board Region		521,930	10,177	5,109	50	5,068	50
West Riding Administrative Area		1,677,260	30,130	19,045	63	11,085	37

Domiciliary Midwifery:

At the end of the year, there were 429 midwives employed in the administrative county, as follows:—

262 by the County Council (including 66 home nurse/midwives).

154 by Hospital Management Committees.

13 in private practice.

There were 11,009 deliveries attended by County Council midwives, of which 9,950 cases had contracted with medical practitioners for the provision of maternity medical services. Two thousand and twenty-seven of these were attended by a general practitioner. In 1,059 cases, a doctor was not booked but, in 74 of these cases, a doctor was in attendance.

The number of cases delivered in institutions but attended by domiciliary midwives on discharge was:—

	<i>Cases</i>
Up to and including the fifth day	2,038
After the fifth but before the tenth day	3,738
Total	<u>5,776</u>

Early discharge from hospital, particularly in certain areas, does increase the work of the midwife.

STAFF SITUATION:

Apart from isolated instances, the West Riding County Council do not share with other authorities the apparent shortage of midwives, except in relation to the combined home nurse/midwifery appointment which remains difficult to fill.

The establishment is 280 whole-time midwives, and 262 (whole-time equivalent of 227·5) were in employment at the end of 1962. These are made up as follows:—

Whole-time midwives	193
Part-time midwives	3
Home nurse/midwives	66
Total	<u>262</u>

STAFF CHANGES:

There were 20 new appointments, 13 resignations, 6 retirements, 1 midwife transferred to health visiting, 2 retired because of ill-health and 1 died.

CASE LOADS AND CHANGING TRENDS:

The trend towards hospital delivery with or without pre-planned early discharge is slowly, in most areas, having an effect on the case load of the individual midwife. However, while the number of domiciliary deliveries may decrease, the amount of time required to cover an area does not do so. There is an increase in the number of general practitioner antenatal clinics with the midwife attending, and also—in some areas—in the number of antenatal classes and clinics held by the midwife alone. These clinics do not attempt to detract the antenatal mothers from the doctor's clinic, but to give them the chance to see a midwife who can give some time to answering questions for reassurance, etc. In these days when hospital clinics are working at such high pressure, many mothers appreciate the informal and tranquil atmosphere of midwife clinics.

Mothers now appear to be up and around so early following delivery, but this fact does not really reduce the responsibilities of the midwife. The emphasis is now on guidance and teaching rather than personal and physical care, but this work is equally important and time-consuming. The domiciliary midwife will certainly be required for a long time yet, but her work will be quite different from that of her counterpart of 20 years ago.

EMERGENCY OBSTETRIC UNITS:

There were 38 reported calls on this service, mostly for difficulties connected with the third stage of labour. The units were supplied by the undermentioned hospitals:—

St. Helen Hospital, Barnsley.
St. Luke's Hospital, Bradford.
The General Hospital, Halifax.
The General Hospital, Harrogate.
The Royal Infirmary, Huddersfield.
The Maternity Hospital, Leeds.
Montagu Hospital, Mexborough.
Jessop Hospital, Sheffield.
The General Hospital, Wakefield.

PREMATURE BABIES:

Following the 1961 survey on premature babies born at home, it was decided to bring up to date the midwives' knowledge on the subject.

Lectures were given in different parts of the County by Consultant Pædiatrics Dr. M. F. G. Buchanan, Dr. C. C. Harvey, Dr. W. Henderson and Dr. J. D. Pickup. The lectures covered:—

- (a) Immediate care of the premature infant at birth.
- (b) Transportation of the infant to hospital.
- (c) Actual care and feeding of the infant at home.

All staff were expected to attend one or other of these lectures and, in addition, midwives who had not had experience in a premature baby unit within the last five years attended a day's course in such a unit.

The co-operation of the Pædiatricians and the Matrons at the following hospitals is appreciated:—

St. Mary's Hospital, Leeds
The Maternity Hospital, Leeds.
The City General Hospital, Sheffield.
St. Luke's Hospital, Bradford.
Bank Hall Hospital, Burnley.
Fulford Maternity Hospital, York.
Jessop Hospital, Sheffield.
St. Helen Hospital, Barnsley.
The Children's Hospital, Bradford.
The General Hospital, Harrogate.

Prematurity remains the most common cause of neonatal death. The aims should be prevention by better antenatal care, including medical and hæmatological examination, careful survey of social conditions, etc., which is not, of course, the sole responsibility of the midwife, but she will often be the only person present when such a baby arrives. The above instruction was given to bring up to date the knowledge of practising midwives on the immediate care of the premature baby and how best to transfer the baby to hospital.

The day spent in hospital had additional benefits, one important one being the contact with institutional midwives which helps each side towards a better understanding of the other's difficulties and problems. The midwives saw the latest incubators in use, with all their technical details, and medical conditions occurring in some infants, which should prove valuable in assessing very early any departure from the normal occurring in their own practices.

A plan was prepared during 1962 to provide portable incubators (carried in ambulances wired for the purpose) for the transport of premature babies from home to the nearest hospital specialist unit. Implementation has been delayed by the finding that available incubators of this type are not entirely satisfactory, and a new, improved design should be on sale in 1963 which, we are assured, will meet our needs.

POST CERTIFICATE INSTRUCTION:

Forty-five midwives attended approved refresher courses at the following centres—Stoke on Trent, Kingston upon Hull, Westcliff on Sea, Bangor, Birmingham, Leeds and Hastings.

IN-SERVICE TRAINING:

An in-service training course was held at Grantley Hall in October, the subject being antenatal care and education. Twenty-eight domiciliary midwives attended, together with five from the County Boroughs of Dewsbury, Doncaster, Halifax, Wakefield and York.

TRAINING OF PUPIL MIDWIVES:

Twenty-seven pupil midwives were trained in the practice of domiciliary midwifery in accordance with the regulations of the Central Midwives Board governing second period training. The pupils were from:—

Fulford Maternity Hospital, York...	...	21 pupils
Western Hospital, Doncaster	... ..	5 pupils
Manygates Maternity Hospital, Wakefield		1 pupil

CARS:

One hundred and eighty-two midwives use their own cars in their work and 7 midwives use cars provided by the County Council.

The County Council have, since 1948, provided a fleet of cars for use by the home nursing staff in continuation of the policy adopted by the former District Nursing Associations, and, until now, cars have only been made available to midwives exceptionally when the needs of the home nursing service have been met. The position has been reviewed and, in future, county cars will be made available to nursing staff generally.

ANALGESIA:

The provision of apparatus for the administration of trilene as an alternative to gas and air has been completed and, at the end of the year, 261 trilene inhalers and 296 gas and air machines were in use or held in reserve. The number of patients receiving trilene has continued to increase—7,559 in 1962 compared with 5,488 in 1961—and there has been a corresponding reduction in the number receiving gas and air, from 2,684 in 1961 to 822 in 1962.

In addition, pethidine was administered alone or in combination with either gas and air or trilene.

The following table indicates the extent to which analgesics as a whole were used within each divisional area.

Div. No.	Area					Percentage receiving Analgesia					
						Pethi- dine alone	Gas and air alone	Gas and air with Pethi- dine	Tri- lene alone	Tri- lene with Pethi- dine	Total
1	Skipton ...	...	...	...	...	8	3	8	19	49	87
3	Keighley ...	...	...	...	...	6	7	10	11	58	92
4	Shipley ...	...	...	...	...	7	1	5	16	65	94
5	Horsforth ...	...	...	...	...	3	—	—	28	60	91
7	Ripon/Harrogate	...	...	...	...	4	4	6	23	54	91
9	Wetherby ...	...	...	...	...	2	5	25	25	37	94
10	Goole ...	...	...	...	...	6	3	3	52	21	85
11	Castleford ...	...	...	...	...	1	4	—	66	15	86
12	Pontefract ...	...	...	...	...	18	1	17	16	36	88
13	Morley ...	...	...	...	...	5	1	1	19	60	86
15	Batley ...	...	...	...	...	6	—	—	35	47	88
16	Rothwell ...	...	...	...	...	6	1	2	27	50	86
17	Spenborough ...	...	...	...	...	2	1	—	31	50	84
18	Brighouse ...	...	...	...	...	5	5	7	16	60	93
19	Todmorden ...	...	...	...	...	3	5	11	26	49	94
20	Colne Valley ...	...	...	...	...	6	8	22	20	32	88
22	Wortley ...	...	...	...	...	28	1	1	22	25	77
23	Hemsworth ...	...	...	...	...	13	—	4	30	41	88
25	Barnsley ...	...	...	...	...	5	4	3	29	42	83
26	Wath/Mexborough	...	...	...	...	6	2	3	27	43	81
27	Adwick/Doncaster	...	...	...	...	11	1	3	25	50	90
29	Thorne ...	...	...	...	...	18	3	11	9	47	88
31	Rotherham ...	...	...	...	...	26	1	1	14	36	78
	Leeds Hospital Board Region	...	...	...	...	6	3	7	28	45	89
	Sheffield Hospital Board Region	...	...	...	...	14	2	3	22	42	83
	West Riding Administrative County	...	...	...	...	10	2	5	25	44	86

HEALTH VISITING

During 1962 emphasis has been placed on liaison between general practitioners and health visitors. The reason behind this is to create a good community service which embodies both preventive and curative aspects. The general practitioner is the pivot of the domiciliary medical care so it would seem sensible to foster plans for linking the services together.

In the greater part of the West Riding there is informal liaison between general practitioners and health visitors but in some areas various special arrangements have been made with general practitioners who have asked for the services of a health visitor. These range from the health visitor visiting the surgery once a week or by telephone calls at certain times of the day to the definite attachment of a health visitor to the general practitioner, whereby she takes his patients on to her case load. Where these schemes have started they have developed rapidly and the weekly visit to the surgery has become more frequent.

In Featherstone and Pontefract both health visitors and home nurses call on the general practitioners and this brings about good team work.

Dr. Cusiter, Divisional Medical Officer (Wath), who started a scheme last year, has this to say:—

“ Miss M. L. Hampshire, a health visitor at Mexborough, assumed duties as liaison health visitor with the practice of Doctors Bhatia, Fleming and Mazey in December, 1962. Weekly visits are made to the surgery to see the doctors, but urgent cases are referred by telephone in between visits.

In Thurnscoe a good working relationship has been established between all the health visitors in that area and the main practice. One of the three partners attends as Medical Officer at our infant welfare clinics and a regular exchange of information is made at the clinics.”

Again, in Ackworth where the general practitioner does infant welfare sessions, liaison with the health visitor is excellent.

Dr. McDonagh has gone further in Keighley and has attached health visitors directly to general practitioners, taking on their case load. This system appears to be working extremely well. The general practitioners are satisfied and the health visitor feels she is doing better work. The disadvantage to this system is that if every health visitor is not mobile, travelling time might outweigh the benefits.

It would seem that more schemes should be tried in order to ascertain which gives the best community service.

Formal health education is growing rapidly and this takes up a good deal of the health visitor's time.

Work with the aged is still very high and Dr. Caithness, Divisional Medical Officer (Batley), reports:—

“ Other Visits

As in previous years a high proportion of these visits was in respect of the welfare of the elderly. Supervisory visits are paid to elderly persons on discharge from hospital—at the request of Almoners.

All cases awaiting admission to geriatric wards are the subject of an environmental report to the geriatric physician. Where necessary ‘ follow up reports ’ are also sent but a high proportion of cases are admitted within 4 weeks of the first report. The majority of these reports are completed by one health visitor who, in addition to this work, pays many visits to elderly patients in need of care and attention from the domiciliary services.

Primary visits ...	...	...	111
Total visits ...	...	...	295

In addition to the above hospital reports 304 visits were paid concerning the general welfare of the elderly. These latter cases are brought to the notice of the department in a variety of ways:—

- (a) Referred by general practitioners.
- (b) Reported by home helps.
- (c) “ Discovered ” by health visitors during routine visits on district.
- (d) Reported by home nurses.
- (e) Reported by public health inspectors.
- (f) Reported by outside organisations (e.g., N.A.B.) and neighbours.

The number of cases of such elderly persons and the amount of work involved in their investigation increases year by year.”

A survey of health visiting was done in Division No. 25, and Dr. Barnes, Divisional Medical Officer (Barnsley), has sent in the following report:—

“ The survey was first devised in relation to the ten year plan. It was felt that many Health Visitors were unable to carry out their visiting duties properly because they were spending too much time on work which could be carried out by some lesser qualified nurse. It was to determine the amount of time, spent by the Health Visitor in her various activities, that this survey was conducted. It was also intended that it should demonstrate as far as

possible, to what extent 'clinic nurses' were carrying out the functions envisaged when they were appointed. Such clinic nurses had been appointed in lieu of qualified staff, because it had not been possible to recruit Health Visitors, and they were contained within the health visiting establishment.

The survey covers the work carried out by twelve health visitors and two clinic nurses during one calendar month. The month of May was chosen because of its relation to school holidays and it was felt that it was fairly typical in this respect. Excluding Saturdays and Sundays there were 23 working days in the month, which gives a possible analysis of 322 nurse/working days. During the month 291½ days were actually worked, the remainder being accounted for by 3 days sickness, 24 days holiday, and 3½ days refresher course. One nurse could not be strictly compared with another, because they had worked different numbers of days in the month. Each activity was therefore divided by the number of days worked and multiplied by five, in order to relate the work to a standard working week.

The twelve Health Visitors were further subdivided into two groups, consisting of eight who had no clinic nurse assistance, and the remaining four who did have such assistance. Three columns of activity were then prepared, which showed work carried out by an average health visitor without assistance, an average health visitor with assistance, and an average clinic nurse. Such staff worked an average of 39 hours 3 mins, 38 hours 22 mins, and 38 hours 14 mins respectively. The time spent on clerical work was high but it was felt that work such as the writing up of visiting cards was personal to that particular Health Visitor. On the other hand, the clinic nurse is able to relieve the health visitor of such work as certifying home help forms, for periods of upwards of one hour per week. Clerical work in association with the sale of foods amounted to approximately 45 minutes per week. This average was inflated by two particular cases which were highlighted by the survey. In these two instances the food has been taken over by clerks subsequently so that currently the average time taken is less than twenty minutes per week. Clinic nurses were obviously doing a great deal in relieving health visitors in the work of setting up and clearing away clinics. School hygiene inspections took much time and more time was actually spent by the Health Visitors with assistance. It must be appreciated that clinic nurses were stationed in 'B type' clinics, in areas of relatively larger populations; so that a given task might well be greater there, than in a smaller area covered by a health visitor without assistance.

In the field of antenatal clinics the clinic nurse can completely relieve the health visitor in helping the midwife to run the clinic. The only time spent by qualified staff under this heading, was that necessary for the health visitor to give talks at relaxation classes. Where the Cranbrook Committee recommendation, that general practitioners should use our premises for their own clinics, has been implemented, then the amount of time spent by midwives and clinic nurses at clinics is increased enormously. This is well illustrated at Worsbrough, where the survey showed the clinic nurse spending just over seven hours per week in antenatal clinics. This trend in co-operation is to be encouraged but it does need more staff time.

The most encouraging trends in this survey were the very satisfactory way that the clinic nurse could relieve the health visitor of home help supervision visits, and this was compensated by such a health visitor spending substantially more time on infant visiting, and on formal health education. The clinic nurse in Wombwell is spending exactly ten hours per week in geriatric visiting, and covering in this period some fifty cases. It would appear from the survey that the average health visitor without assistance has little or no time for formal health education. Many health visitors felt that they were behind with routine infant visiting.

The time taken up in travelling was studied carefully, but this yielded little of significance. There was a tendency for those with cars to fetch and carry for those without thus evening out any differences which might otherwise have been apparent. One health visitor was spending only a few minutes short of six hours per week in travelling, but otherwise most staff were around the average.

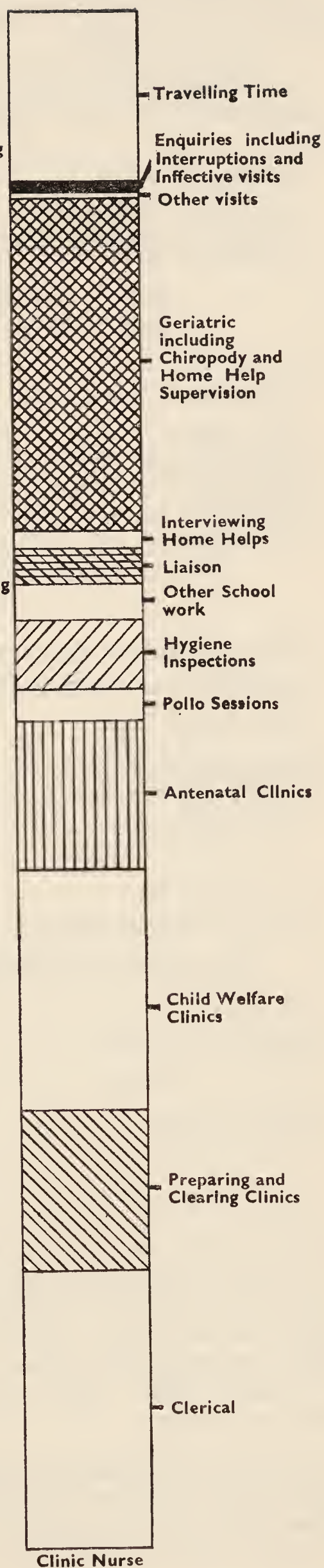
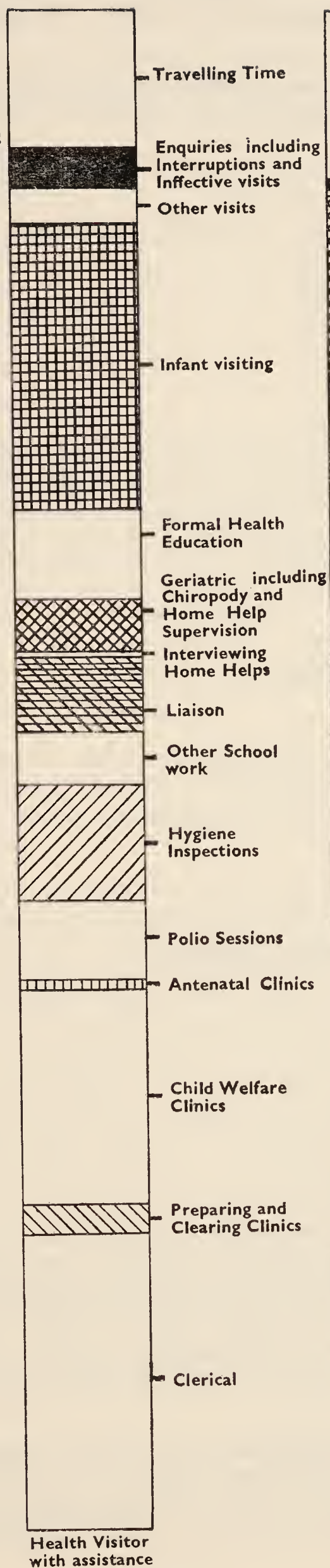
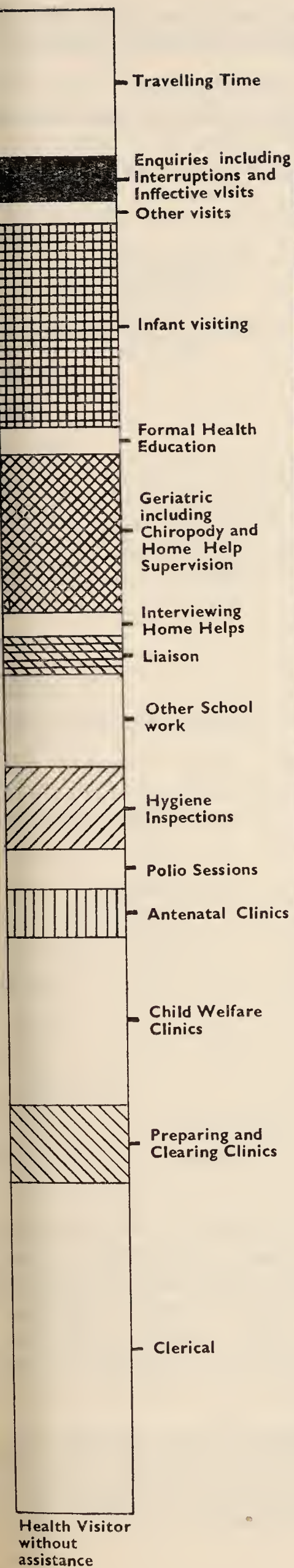
The conclusions reached in this survey were that the clinic nurses were doing a good job along the lines envisaged when they were appointed. Despite this assistance some health visitors were still doing work which could have been handed over. This survey was conducted with a ratio of two health visitors to one clinic nurse. Later a ratio of two to two was tried at Wombwell. It was felt that this latter ratio was probably a little excessive. It was felt that some account must be taken of work which health visitors should be undertaking, but which at present is only being done in a very limited way. Visits associated with hospital liaison are increasing, and yet these are all included within forty minutes per week allocated to 'other visiting'. At the time of this survey audiometry was only being done in a very limited way, but since that time this has increased considerably, and such an increase can only have taken place at the expense of some other work. It is thought that

the survey shows a definite need to relieve the health visitor of some tasks, and that such dilution could take place without any detriment to the service. It is tentatively suggested that a more modern establishment of staff could be calculated on the basis of one clinic nurse and two health visitors for each population of 10,000.

The results of the survey, shown statistically and graphically follow."

Notes on compiling the health visitor activity columns

<i>Item</i>	<i>H.V. without assistance</i>	<i>H.V. with assistance</i>	<i>Clinic Nurse</i>
Clerical	8 hrs 36 mins	7 hrs 33 mins	6 hrs 55 mins
Preparing and clearing clinics...	1 hr 58 mins	48 mins	4 hrs 0 mins
I.W.C.	4 hrs 22 mins	5 hrs 22 mins	6 hrs 0 mins
A.N.C.	1 hr 16 mins	16 mins	3 hrs 45 mins
School Hygiene	2 hrs 5 mins	2 hrs 53 mins	1 hr 43 mins
Other school work	2 hrs 27 mins	1 hr 24 mins	52 mins
Formal Health Education ...	42 mins	2 hrs 13 mins	—
Polio Sessions	1 hr 0 mins	1 hr 58 mins	45 mins
Liaison	1 hr 1 min	1 hr 50 mins	54 mins
Interview Home Help... ..	41 mins	8 mins	25 mins
Home Help, etc., Visiting ...	4 hrs 8 mins	1 hr 25 mins	8 hrs 12 mins
Infant Visiting	5 hrs 15 mins	7 hrs 15 mins	—
Enquiries, ineffective visits, etc.	1 hr 9 mins	57 mins	19 mins
Other Visiting	40 mins	50 mins	8 mins
Travelling time	3 hrs 43 mins	3 hrs 30 mins	4 hrs 16 mins
<hr/>			
Total ...	39 hrs 3 mins	38 hrs 22 mins	38 hrs 14 mins
<hr/>			



The health visitors have been given an additional task this year—that of testing small babies for congenital hip defects. A separate account of this will be found on page 103.

An analysis of the work undertaken by health visitors during the year is given below:—

Analysis of Visits

Expectant mothers	...	...	...	...	...	...	...	9,526
Children under 1 year	...	...	...	...	...	...	150,277	
aged 1—2 years	...	...	...	...	...	...	70,572	
aged 2—5 years	...	...	...	...	...	...	180,636	
							<hr/>	329,485
Tuberculous households	...	...	...	...	...	...	...	7,889
Other cases	...	...	...	...	...	...	...	188,156
School health	...	...	...	...	...	...	...	17,727
Ineffective	...	...	...	...	...	...	...	49,662
							Total	<hr/> 602,445 <hr/>

Clinic and School Sessions

Maternity and Child Welfare	...	...	...	...	...	...	...	28,045
Ultra Violet Light	...	...	...	...	...	...	...	1,387
Health Education—								
a. Clubs	...	...	...	...	...	...	...	130
b. Parent teachers	...	...	...	...	...	...	...	138
c. Schools	...	...	...	...	...	...	...	1,091
d. Antenatal classes	...	...	...	...	...	...	...	238
Other health education activities	...	...	...	...	...	...	...	1,232
							<hr/>	2,829
Specialist—Chest	...	...	...	...	...	...	...	1,613
Other	...	...	...	...	...	...	...	1,724
School Health	...	...	...	...	...	...	...	18,961
							Total	<hr/> 54,559 <hr/>

Home visits, in all cases except school health, have increased by 16,775 visits over the previous year. The greatest increase in home visits by 12,076 is in the category of “others” which includes visits to the aged—liaison visits to various people including the general practitioner, hospital and voluntary agencies. Other notable increases are to children under 1 year, 1,934; 1—2 years, 3,470; 2—5 years, 3,102. The number of families visited was 98,032, an increase of 9,418 on last year.

The present staffing establishment for health visiting, school nursing and tuberculosis visiting is 341 whole-time officers. At the end of the year 340 staff (equivalent of 310·8 whole-time officers) were employed on these services (about the same number as the previous year)—made up as follows:—

Qualified health visitors (8 part-time) combining the duties of health visiting and school nursing.	249
Assistant health visitors (28 part-time) without the health visitors' certificate, combining duties in the public health and school health services, 12 of whom also undertake health visiting under dispensation granted by the Ministry.	80
Whole-time school nurses.	3
Home nurse/midwife undertaking duties of health visiting, home nursing, midwifery.	1
Whole-time tuberculosis visitors.	7
	<hr/> 340 <hr/>

There were 49 new appointments (19 of these were unqualified), 32 resignations (10 unqualified), 4 retirements and 1 transfer to other services, and 7 unqualified health visitors transferred to student health visitors. Miss Bramley was appointed Divisional Nursing Officer for the Colne Valley (No. 20) Division. Miss Jones retired from the post of Area Nursing Officer in December, 1962.

Post Certificate Training:

Twenty-nine health visitors attended approved courses organised by the Health Visitors' Association and the Royal College of Nursing and Miss Walker attended a conference on health education organised by the Health Visitors' Association.

Fifty members of the staff attended an in-service training course at Grantley Hall, eighteen of these were from the Mental Health Section as the course was organised conjointly with the Mental Health Section. The object of this course was to bring together health visitors and mental welfare officers so that they could work out some system of welding prevention and treatment together. It was a give and take period where everyone tried to understand his or her opposite number's problems and it also showed that both field workers basically deal with similar problems. The speakers were Dr. J. M. Roberts, M.D., D.P.M., Consultant Psychiatrist at St. James's Hospital, Leeds, who gave two lectures on "Psychological Aspects of Disability and Re-habilitation"; Dr. E. Gore, M.D., D.R.C.O.G., D.P.M., Consultant Psychiatrist at Harrogate Child Guidance Clinic, who spoke on "The Family—the effects of mental disturbance in the family". Two films were shown and the course ended with a forum composed of Dr. Lyons, Deputy County Medical Officer, who took the chair, Dr. Jeremiah, Senior Administrative Medical Officer, Mrs. Farrow, Psychiatric Worker-Tutor, Miss Edwards, Deputy County Nursing Officer, Mr. J. H. Hope, Senior Mental Welfare Officer, Mrs. Corless, Divisional Nursing Officer and Miss A. Ridsdale, Health Visitor. There was a great variety of questions which were answered ably by the members of this competent panel.

This course was followed by a two day course on "The Prophylaxis of Mental Illness", organised by the Central Council for Health Education. Hemsworth Clinic was the centre and it was attended by the same members of staff who went to the course at Grantley Hall.

Another two day in-service training course was also given to health visitors on "Progress in Health Education". This was arranged jointly with the Central Council for Health Education and was held in South Elmsall Clinic. Fifty health visitors attended.

Group lectures for health visitors were arranged in Wombwell, Bingley and Tadcaster—the lecturer was Mr. R. B. Zachary, Consultant Pædiatric Surgeon, and he spoke on "Modern Trends in the Surgery of Childhood".

Miss Seelig, Divisional Nursing Officer, Morley and Miss Crossfield, newly appointed Divisional Nursing Officer, Hemsworth, both commenced the course on Public Health Administration in September, 1962, at the Royal College of Nursing. The course lasts one academic year.

Student Health Visitors:

The following report is submitted by the Tutors at Leeds:—

"The recruitment of candidates for health visitor training is still a problem, but sixteen students sponsored by the County Council registered at Leeds University in October, 1961. They were joined in the second term by the student who had to withdraw because of illness in the previous year. Of these, all have qualified, though one lady had to take the examination twice. The total number of students was forty-nine.

Although one tends to take it for granted, the good standard of practical instruction and the interest shown in students is both heartening and encouraging. The Day Books kept by the students reveal this, as well as the enthusiasm with which impressions are voiced in casual conversation. We would like to thank all those who have contributed in any way to the practical training which takes place in the West Riding, Leeds and adjacent County Boroughs. Also we would like to thank Miss Coleman for her valuable incidental assistance.

Professor Bradshaw offered a prize this year. Miss N. Harris, a West Riding student, was awarded this, though not without some competition from other members of the class.

Miss F. M. Mawson retired in August, 1962, having spent many years as the Health Visitor Tutor for Leeds City. Together with the County Health Visitor Tutors she has been concerned with the training of Health Visitors for the West Riding and elsewhere."

Cars:

Two hundred and twenty-three health visitors use cars on County business.

HOME NURSING

Staffing:

During 1962, there has been no shortage of home nurses. Indeed, there is a waiting list of State Registered Nurses seeking convenient vacancies. There is still, however, difficulty in obtaining nursing staff for combined duties, and serious thought has been given to splitting the duties of midwifery and home nursing where the case load and distances lend themselves to such a division. The number of nurses employed is slightly higher than in 1961.

The establishment is 290 whole-time nurses, and 312 (whole-time equivalent of 271) were in employment at the end of 1962, an increase of 15 on the 1961 figures. These were made up as follows:—

Home nurses, S.R.N. (11 part-time)	...	...	234
Senior relief home nurses, S.R.N.	...	...	2
Home nurse/midwives, S.R.N. (1 part-time)	...	...	62
Home nurses, S.E.N. (2 part-time)	...	...	10
Village nurse/midwives, S.E.N.	...	...	4
			—
			312
			==

There were 42 appointments, 17 resignations, 7 retirements, and 3 transferred to other services.

Training:

The first of the training courses for district nurses operated by the West Riding County Council began in May, 1962. The course was of three months' duration for nurses with not less than eighteen months' district nursing experience, qualified midwives and qualified health visitors. For others, it covered four months.

The practical training was given in adjacent districts by experienced senior home nurses approved by the Queen's Institute for this purpose. The Tutor and Divisional Nursing Officer also supervised some of the work. The theoretical training, comprising three weeks of lectures, was given at the Bradford or Sheffield training centres.

Throughout the course, the students spent one day each fortnight at headquarters for tutorials, discussions and demonstrations of nursing techniques.

On completion of the course, there was a practical examination by one of the Queen's Institute examiners and a written examination set by the Queen's Institute. Successful candidates received the Queen's Certificate and the Ministry of Health Certificate.

There were 10 students for the first course and 8 passed the examination. The second course, which commenced in September had 9 students, and these students—plus the two failures—all passed the examination.

Half the first group of students were home nurses who had been employed by the West Riding County Council for many years. They were most appreciative of being able to take this course without disrupting their domestic commitments.

In connection with this course, Mrs. Taylor (Acting Tutor), Mrs. T. Pickersgill (Morley) and Mrs. M. McNaney (Castleford) attended a week's course at the William Rathbone College, Liverpool, for senior home nurses who were responsible for training student district nurses.

Refresher Courses:

Once again, a successful course was held at Grantley Hall in July, 1962. Thirty-eight West Riding students attended. The course was run on similar lines to the one in 1961 and observation visits were paid to three hospitals, Leeds General Infirmary—where the nurses were shown the modern equipment used in heart operations and also saw patients receiving treatment and care after the operations, the Geriatric Unit at St. James's Hospital, and the Cancer Unit at Cookridge Hospital. The nurses felt these observation visits had given them an insight into new methods of treatment and rehabilitation of the aged.

Cars:

Two hundred and four home nurses use cars in connection with their work and, of these, eighty are provided by the Authority.

Housing Accommodation for Nurses:

The Sub-Committee, appointed during 1961, visited all houses owned by the County Council and occupied by nursing staff with a view to improving the accommodation where necessary and providing better amenities. As a result of these inspections, a considerable number of improvements to houses have been undertaken.

Day and Night Nursing Service:

Towards the end of the year, the scheme approved in 1961 for the provision of a day and night nursing service for cancer and other types of patient was introduced. So far as cancer patients are concerned, the scheme is operated jointly with the Marie Curie Memorial Foundation who meet the cost in full; the cost of providing the service for other types of case is met by the County Council.

The object of the scheme is to provide a day or night nursing service without charge to the recipient for a temporary period, usually in an emergency or during the terminal stage of illness, to provide a relief to relatives who may be under considerable strain resulting from caring for the patient over a long period. Trained nurses, persons with nursing experience, or "sitters-in" can be employed in the scheme and Divisional Medical Officers are compiling a register of persons who are suitably qualified and who are willing to offer their services when called upon.

The value of a scheme of this kind is well illustrated in the following report submitted by Dr. Watt, Divisional Medical Officer (Rotherham):—

"The service to patients sponsored by the County Council and the Marie Curie Memorial Foundation is at present run jointly, and commenced with the appointment, on a part-time basis, of one trained nurse and one auxiliary.

The need arises in the following circumstances:—

- (a) where a hospital bed is not available or the patient does not wish to be moved from his home, or
- (b) where there are no relatives capable of providing care and attention, or where such have already been provided over long periods of sickness and the relatives are on the point of imminent breakdown due to the stress and strain of giving day and night attention, particularly in cases where relatives are attempting to follow normal daily routine at home or at work.

Since the commencement of the scheme, some ten patients have been referred for service, seven of whom have been serviced for periods from one to four weeks. In two cases, it was not possible to provide the service as their homes were remotely situated, and the remaining case died before the service commenced. Of these cases, one had day service and the remainder night service from 10 p.m. to 6 a.m. on one or two nights per week. Most of the patients had been referred by home nurses; one application came from the relatives.

Summary of Cases

1. Male patient, aged 47; carcinoma of stomach and throat, secondaries of spine.

Patient lived with his wife and family—a daughter of 17 and a boy of 9, the girl being out at work. The patient had been ill for almost a year. His wife, with the help of a friend, had given all the general nursing care that had been required, and it was not until morphia was ordered that this case came into the home nurse's care. At this stage, the wife was in an extremely dispirited and dejected state, and it was obvious to any casual observer that she had not slept for a long time. The fact that the patient was not aware of his condition was an added strain to his family. A hospital bed had been requested by the patient's doctor, but had not been made available. The patient died two weeks after night nursing became necessary.

2. Male patient, aged 72; carcinoma of stomach and lungs

The patient was not receiving trained nursing care and was referred by the son. The wife, living with patient, was aged 70 years. The patient's medical attendant was concerned as the wife had been sitting with her husband at night and losing sleep, relieving a married son who had been sitting up with his father and was losing employment in consequence. A night nurse arranged to attend twice weekly but the patient died during the first week of the arrangements.

3. *Male patient, aged 67; hemiplegia and cardiac conditions.*

This patient lived with his married daughter who had two small children, the daughter caring for her father and the nurse attending twice daily. The man was a difficult patient, knocking for his daughter most of every night, and one night—whilst attending her father—she suffered a heart attack. Her doctor was greatly concerned and renewed his previous request for a hospital bed, the patient already being on the waiting list. At this point a request was received for the provision of a night nurse. The nurse attended twice weekly and, at the end of the first week, a hospital bed became available. The daughter refused the bed on her father's behalf, giving as a reason that—with the help she now had—she could care for her father until he died, which event occurred four weeks later.

4. *Female patient, aged 70 years; cardiac condition.*

The patient had lived alone until her recent illness when her son took her to live with him and to care for her, both son and wife being in full-time employment. The daughter-in-law then gave up her employment to care for her mother-in-law and, together with her husband, nursed the patient, relieving each other for night duty. The night nurse attended once weekly to relieve the strain. At the end of the second week, the patient died.

5. *Female patient, aged 67; carcinoma of rectum, bladder and secondaries.*

The patient was living with a man as his housekeeper and was attended by home nurses twice daily, having been recently discharged from hospital as incurable and inoperable. For a period, a grant was made from the Samaritan Fund of the Sheffield Radiotherapy Centre for a sitter service and, upon its expiration, an auxiliary was sent in daily to bridge the gap between the man leaving for work and friends visiting at 5 p.m.

6. *Female patient, aged 44; carcinoma of bladder and colostomy.*

The patient lived with her husband and two children aged 9 and 7, and had been discharged from hospital as inoperable; she was in a poor condition. The patient became very agitated if she thought her husband was away from his employment, and so was inclined to refuse his help at night. The home nurse visited four times each day and the night nurse attended two nights each week until the patient died.

7. *Male patient, aged 58; cerebral, almost completely paralysed.*

The wife of this patient was extremely overtired by constant sitting up and caring for the patient. Nurse attended one night per week. There was no family, and the wife was extremely grateful for all the help she received.

To summarise, it is considered that the service is well worthwhile and is meeting a real need in the community. Difficulties are apparent in its administration, e.g., terminal cases of carcinoma, sponsored by the Marie Curie Memorial Foundation, must be defined as to degree of termination before committing the Foundation to any expenditure and, whilst medical opinion can be sought in this respect, there are obvious difficulties in giving this advice. Cases must be selected carefully so that the service is offered only to those for whom it is intended, whilst—at the same time—it is necessary to maintain a steady flow of work to retain staff in post. It is also necessary to try and avoid unnecessary travelling over long distances and, at the same time, to keep the number of staff engaged on the service to a minimum.

The cost for the above cases was approximately £40 0s. 0d., whilst the cost of hospitalisation for one case alone could have been much greater; all other cases would have accepted a hospital bed had one been available. The scheme achieves economy in public expenditure and, at the same time, fills a gap in the service, and could play an important part in the future, particularly in relation to the major developments that are to take place in the reorganisation of the health services.

In conclusion, the expressions of gratitude received from the relatives were quite outstanding, possibly due to the fact that the service came to them unexpectedly, and at a time when their own efforts reached maximum proportions and their vitality was at its lowest ebb."

Summary of the Work of Home Nurses:

The total number of cases dealt with by the home nurses was 27,126 as compared with 30,946 in 1961, a decrease of 3,820. The total number of visits to patients has also decreased by 44,375, approximately 163 visits per nurse less

than in 1961. The only figures which have remained steady are those for treatment of tuberculosis. There have been slight increases in cases and visits to infectious diseases and maternal complications. There are, in addition, many more patients receiving more than 24 visits per year.

The following table is a summary of the total work undertaken during the year by the home nurses.

<i>Types of cases attended</i>							<i>No. of cases attended</i>	<i>No. of visits by Home Nurses</i>
Medical	...	...	...	...	...	...	20,054	574,350
Surgical	...	...	...	...	...	...	6,012	130,643
Infectious diseases	...	...	...	...	...	...	122	473
Tuberculosis	...	...	...	...	...	...	345	23,794
Maternal complications	...	...	...	...	...	...	424	3,731
Others	...	...	...	...	...	...	169	2,054
Total							27,126	735,045

<i>Age Groups</i>								
0—4	...	...	...	...	...	...	1,088	8,567
5—65	...	...	...	...	...	...	11,596	255,163
Over 65 years	...	...	...	...	...	...	14,442	471,315
Total							27,126	735,045

Patients included in the above who have had more than 24 visits during the year							7,808	501,891
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On 1st January, the records of the home nursing service were revised to provide information of the work undertaken in greater detail than previously; it may be that this method is bringing out certain aspects of the work which hitherto had gone unnoticed. The following tables give details of cases completed during the year, i.e., excluding cases still under treatment at the 31st December.

Classification of Cases by Disease:

<i>Disease</i>									<i>No. of Cases</i>
Tuberculosis	...	...	...	...	...	...	...	...	266
Other infectious diseases	...	...	...	...	...	...	...	...	122
Parasitic diseases	...	...	...	...	...	...	...	...	23
Malignant and lymphatic neoplasms	...	...	...	...	...	...	...	...	1,369
Asthma	...	...	...	...	...	...	...	...	67
Diabetes mellitus	...	...	...	...	...	...	...	...	428
Anæmias	...	...	...	...	...	...	...	...	1,394
Vascular lesions affecting central nervous system	...	...	...	...	...	...	...	...	1,471
Other mental and nervous diseases	...	...	...	...	...	...	...	...	351
Diseases of the eye	...	...	...	...	...	...	...	...	96
Diseases of the ear	...	...	...	...	...	...	...	...	326
Diseases of heart and arteries	...	...	...	...	...	...	...	...	1,684

Diseases of veins	...	...	...	...	...	...	...	393
Upper respiratory diseases	...	...	...	...	...	...	...	425
Other respiratory diseases	...	...	...	...	...	...	...	1,752
Constipation	...	...	...	...	...	...	...	891
Other diseases of digestive system	...	...	...	...	...	...	...	1,376
Diseases of urinary system and male genital organs	...	...	...	...	...	...	...	821
Diseases of breast and female genital organs	...	...	...	...	...	...	...	432
Complications of pregnancy and puerperium	...	...	...	...	...	...	...	424
Diseases of skin and subcutaneous tissues	...	...	...	...	...	...	...	1,127
Diseases of bones, joints and muscles	...	...	...	...	...	...	...	554
Injuries	...	...	...	...	...	...	...	1,260
Senility	...	...	...	...	...	...	...	1,047
Other defined and ill-defined diseases or disabilities	...	...	...	...	...	...	...	990
Diseases not specified	...	...	...	...	...	...	...	392
Total								19,481

Nursing Treatment:

	<i>Type</i>								<i>No. of Cases</i>
Injections only	5,767
General nursing	6,255
Enemas	1,169
Dressings	4,408
Bed baths	516
Wash-outs, douches, etc.	305
Changing of pessaries	115
Preparation for diagnostic investigation	374
Others	572
Total								...	19,481

The total number of cases receiving injections was 6,379 but, in 612 cases, the injections were given during the course of a general nursing visit.

Injections:

	<i>Type</i>								<i>No. of Cases</i>
Insulin	303
Drugs for anæmia, debility, etc.	1,780
Antibiotics	3,083
Drugs for cardio-renal diseases	817
Others	396
Total								...	6,379

Referral of Cases:

<i>Source</i>								<i>No. of Cases</i>
General practitioners ...	...	...	...	...	...	...	...	15,374
Hospitals ...	...	...	...	...	...	...	...	2,558
Health Department staff	...	...	...	...	...	...	...	978
Others ...	...	...	...	...	...	...	...	571
Total ...								19,481

Disposal of Cases:

								<i>No. of Cases</i>
Convalescent ...	...	...	...	...	...	...	...	10,772
Transferred to hospital	...	...	...	...	...	...	...	3,225
Died ...	...	...	...	...	...	...	...	3,527
Others ...	...	...	...	...	...	...	...	1,957
Total ...								19,481

Although many antibiotics and drugs given for cardio-renal diseases are now given by mouth, the antibiotics are still the largest group which concerns the home nursing service. The cases for injection only are 29 per cent. of the total number of cases undertaken, whilst the number of visits for injection only tends to have dropped to 22 per cent. of total visits in comparison with 32·5 per cent. in 1961.

More time is being spent by the home nurses on the rehabilitation of paraplegic patients and teaching them and their relatives the importance of early mobility. Other aspects of health education are also being dealt with by the home nurse in her visits to the home, particularly in relation to the elderly to whom home accidents so frequently occur. In summarising, it would seem that more time is being spent on a less number of cases and this trend will, I believe, be the pattern for the future.

AMBULANCE SERVICES

The Service is under the control of Mr. V. Whitaker, O.B.E. and I am indebted to him for supplying the following report:—

						Year ended 31st December		Increase on
						1961	1962	1961
Admissions	...	...	...	...	...	46,825	48,077	1,252
Discharges	...	...	...	...	...	25,731	26,790	1,059
Transfers	...	...	...	...	...	11,009	11,456	447
Out-patients	...	...	...	...	...	391,605	404,618	13,013
Accidents	...	...	...	...	...	12 612	13,439	827
Total of Direct Services	...	...	...	...	...	487,782	504,380	16,598
Total of Direct Services plus Agency and Car								
Pool Services	...	...	...	...	...	520,453	542,939	22,486
Mileage of Direct Services	...	...	...	...	...	3,159,377	3,214,998	55,621
Total Mileage (including Agency and Car								
Pool Services)	...	...	...	...	...	3,509,022	3,602,390	93,368

The number of patients conveyed continues to reflect the increasing demands being made on this service. The trend of increasing out-patients has again reflected the Hospital policy of stepping up the use of out-patient clinics in order to relieve bed space in the hospitals. The weekend and night accident cover is under continual review in view of the upward trend of these figures. Should the increase continue at its present rate, it may prove necessary to provide additional manning during the hours when stations are staffed for emergencies only.

To meet the continuing increases shown in the annual returns, an additional seven vehicles have been taken into service, bringing the fleet up to a strength of one hundred and fifty. Of this total, thirty ambulances have been replaced during the year. Steps have also been taken to bring the vehicle fleet into line with the Maintenance and Safety Precautions recommended by the Ministry of Health in Circular 16/62.

The co-ordination of County Ambulance vehicle movement in Sheffield has long been a problem. To facilitate operational planning of vehicle journeys after their arrival at Sheffield hospitals, a Transport Officer was appointed late in the year to operate an Ambulance Control Point similar to the one in Leeds which has functioned so successfully for a number of years.

Two new stations have been built and brought into operation during the year. The one at Bramham replaces unsatisfactory premises on an adjoining site. The one at Sherburn in Elmet is a resiting of the former Garforth station, now closed. The latter was less than a mile from the Leeds City boundary and badly situated in relation to the catchment area of its operation. A new garage has been built

at Pudsey as part of the upgrading of the accommodation there and it is hoped to complete the replacement of staff and office premises next year. A one vehicle station operating from Kiveton Park has been closed. The vehicle has been absorbed into Maltby station, from where the full commitments of the sub-station will be met in future.

As part of the approved scheme for centralising night calls and increasing inter-station co-ordination by improved telephone facilities, the groups of stations centred on Castleford and Hoyland have now been linked by land lines.

The operational emergency of the year was the smallpox outbreak in January and this was a test of readiness for the service which had not been active in this sphere since the Todmorden outbreak in 1953. All emergency arrangements worked satisfactorily and the policy of maintaining annual vaccinations of a number of staff trained in smallpox procedures has been fully justified, the service being in a position to make several crews immediately available.

When a smallpox crew is first called to undertake a removal, they report to the ambulance station where they don a complete change of clothing specially provided and maintained. This consists of:—

Vest.	Calf-length rubber boots.
Long underpants.	Rubber gloves.
Socks.	Surgical cap.
Pullover (if needed).	Face mask.
White boiler suit.	

Meanwhile, a dozen spare sets of protective clothing, plus their personal clothing, are sent to the Isolation Hospital.

On taking the first patient into hospital, the crew with their vehicle, becomes resident there and when not engaged on ambulance work, assist with the work of the hospital. Additionally, there is an informal arrangement in the Leeds Region to use West Riding County Council ambulances for conveyance of all smallpox patients, irrespective of the area of residence. As in the Todmorden outbreak, all the smallpox transport was undertaken by one crew only. This arrangement is economical, reduces the potential risk to ambulance staff and also reduces the number of ambulance staff under surveillance.

Crews are volunteers and know they may be relieved on request but this has not been called for. Procedure followed was that so long as a crew were dealing with a sequence of confirmed or well nigh confirmed cases, they did not change into spare clothing or disinfect the vehicle but if after conveying such a case they were required to proceed straight out for a suspect or contact case, the crew would first disinfect the vehicle, then wash, scrub down and put on clean protective clothing.

Additional to training crews in disinfection and personal hygiene, a special drill has been set down in the event of a vehicle breakdown. The procedures extend to mechanics who would need to tow away the vehicle and provide for its disinfection before repair work could be commenced.

The County Medical Officer, through the Divisional Medical Officers, has arranged for training classes in Extended First Aid, and special emphasis has been given to Mouth-to-Mouth Resuscitation by instruction, films and mechanical aids.

In connection with First Aid in general, eight Station Officers have been examined for and qualified as Lay Demonstrators.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Health Education:

Some 300 years ago Izaak Walton wrote "Health is the second blessing we mortals are capable of; a blessing that money cannot buy". The price that man must pay for this blessing lies to some extent in his acquiring an elementary knowledge of the workings of his body, a basic understanding of the external factors likely to cause ill health and the measures he can take to promote sound health and prevent disease.

Education of schoolchildren in elementary anatomy and physiology is increasing and should stand them in good stead in adult life. External influences are constantly changing and scientific research is ever on the alert to discover any factors likely to prove detrimental to good health.

One such research project was reported upon early in 1962 when the Royal College of Physicians published the result of their survey on "Smoking and Health". As a result of this, a working party was set up in the County consisting of members of the education and health departments. The aim of this group was to consider suitable ways of disseminating the information available on the dangers of cigarette smoking and also to decide which age groups required most attention, bearing in mind the number of staff that such a campaign could absorb. The working party was unanimous in accepting a causal relationship between cigarette smoking and lung cancer and the necessity for a propaganda drive in the schools. It was felt that the example of all members of the staff, and particularly that of the teachers, was of prime importance and the co-operation of the staff in this matter should be elicited. To this end, Dr. Withnell, Divisional Medical Officer (Morley), a member of the working party, prepared a précis of the Royal College of Physicians' report and a copy of this summary was circulated to every member of the County's medical, nursing and education staff, including youth leaders and students in training colleges. In this way the staff were given the basic information necessary to assist them in their own approach to the subject of smoking, and were also enabled to deal with questions that might be put to them on this topical subject.

In addition, it was decided to revise the letters on smoking which had been sent either to schoolchildren, or to their parents. In the revised edition more information was given and it was agreed that initially a copy should be sent to all secondary school children and to the parents of seven-year old children; whilst in future, all entrants to secondary schools and the parents of seven-year old children should receive letters. Some parents have acknowledged these letters with gratitude and I quote from one such reply:—

"My wife and I were very pleased to receive your letter via Adwick Washington School re the dangers involved in smoking and would like to thank you for the action you are taking in this respect. It is encouraging to know that the school and medical officers are doing all they can to ensure that the children are made aware of these dangers, and that we have your support in our advice and example concerning smoking."

In most divisions there have been extensive programmes in connection with "Smoking and Health" and in many areas this subject has provided the major project of the year. In addition to campaigns for the benefit of the general public, medical officers have arranged to show the teaching staff films, film strips, flannelgraphs, posters, charts and leaflets dealing with all aspects of the smoking menace. The teachers then decided what they considered to be the most suitable form of visual aid for their own particular groups of children. Subsequently,

either the divisional medical officer or a member of the medical or nursing staff then undertook to show the film or other teaching media and explain the dangers to health associated with cigarette smoking. Such a programme is very demanding of staff time and also of equipment and because of shortage in some areas, especially of staff, it has not always been possible to give full coverage to this most important aspect of health education.

Consequently, we welcomed the launching by the Minister of Health, in conjunction with the Central Council for Health Education, of two mobile units, to tour the country to deal with the problems connected with cigarette smoking, and a total service by one unit of fifty-three days was requested by our divisional medical officers. The mobile unit first visited us in December when it spent a total of twelve days in the Spenborough, Brighouse, Hemsworth and Barnsley areas. The unit, manned by two graduates, carried the equipment necessary for showing films, film strips and flannelgraphs for teaching purposes. Generally speaking they concentrated on secondary schools, but youth clubs, parent-teacher associations and some industrial firms and clubs were also visited. From Spenborough, Dr. Douglas, Divisional Medical Officer, reports:—

“ For two days in December the area was visited by one of the mobile vans of the Central Council for Health Education, and the opportunity was taken, with the whole-hearted support of the Spenborough Health Committee and Council, to organise a ‘ Stop Smoking Week ’ in the area. Large quantities of posters and leaflets were obtained from central office and were distributed to and displayed by all the large firms in the area as well as the shops, Town Hall, Public Library, Clinics, etc. The local ‘ press ’ gave considerable publicity to this event, but it is, of course, impossible to assess what impact it had on the general public. The distribution of publicity material was so wide that it must have been extremely difficult for anyone in the area to have avoided the facts on smoking placed so squarely before them. The mobile van visited all secondary modern and grammar schools in the area, the film ‘ Spotlight on Smoking ’ shown, lectures given and leaflets distributed. ”

Requests for information on the subject of smoking and health were received from numerous sources including heads of training colleges, students in training, area youth officers, youth leaders, and many voluntary organisations such as church groups, etc. These requests have been acceded to by the staff of both central and divisional offices according to their requirements and have included talks, discussions, films, and the provision of literature.

The connection between cigarette smoking and lung cancer will require repeated coverage over a long period of time, and to help the staff to undertake this successfully the necessary films and other teaching aids have been bought or obtained on long term loan. In this respect the demand for sound film projectors alone has been exceptionally heavy and all the projectors have been in constant use.

The number of leaflets, posters and pegboard displays provided have consequently shown a marked increase as is evidenced by the following statistics:—

	1961	1962
Leaflets	130,000	150,000
Bookmarks	21,700	22,000
Flannelgraphs	60	60
Posters	6,040	17,000
Pegboard displays	14	50

Research to discover the amount of time spent by health visitors on teaching health matters in schools revealed that rather more than one third was devoted to the subject of “ Parentcraft ”. Other subjects covered included “ Personal hygiene and general health ”, “ First aid and home nursing ”, “ Accidents ”, “ Citizenship ”, “ Infectious diseases ”, “ Smoking ”, “ Nutrition ”, “ Sex education ” and “ Cancer ”.

Although some classes are bi-sexual, it is more usual for subjects relating to health education to be given to girls only, especially those relating to parentcraft and personal hygiene. We hope this will be remedied in the near future and that instruction will also be available for boys.

One Divisional Medical Officer reports:—

“ A regular programme of teaching mothercraft and public health has been carried on in seven of our ten secondary modern schools. As all the health visitors teach more or less from the same syllabus they are able to interchange schools in cases of illness or holidays and so the teaching can be continuous.

Each health visitor spends approximately one half day each week in secondary modern schools and at the moment teach only the school leavers, but this teaching could be extended to all pupils if time permitted.

Heads of the other three schools would appreciate the health visitors teaching in schools but owing to shortage of health visitors in this area we dare not start any more projects.

Occasionally, health visitors have gone into junior schools to talk to all children on personal hygiene but this again is very time consuming, when there is plenty of teaching to be done in the homes. ”

A letter of appreciation of the health visitor's teaching was received by Dr. Ferguson, Divisional Medical Officer (Doncaster), and is reproduced here:—

“ May I thank you very much for the continued help of one of your nurses—Miss Osborne.

She has been giving instruction to our senior girls for half an hour every Tuesday for some years, and I cannot express just how much I appreciate and value her services. I am sure our girls benefit greatly from her talks and I have come to regard her work as a most essential part of our curriculum.

Thank you again for her help.

Yours sincerely,

(signed) George T. Stowe,

Headmaster.”

The shortage of health visitors in some areas has resulted in the enforced cancellation of some health education classes in schools whilst in other areas these classes have been taken over by the school teachers who have referred to the divisional medical officers' staff for any necessary guidance and advice. There is, in fact, much variation within the County regarding the amount of health education in schools being undertaken by health visitors.

In the maternity and child welfare clinics, most health visitors carry out health education programmes as a matter of routine and, where relaxation classes are held, the midwives and health visitors provide a combined schedule of topics concerning the health and well-being of the expectant mother and her unborn child. Programmes are planned well in advance so that suitable films or film strips can be obtained and pegboard or other displays made available.

A new venue for health education was reported in 1962, by Dr. Cusiter, Divisional Medical Officer (Wath), who writes:—

“ After hearing about so many young people and families taking a camping holiday, one health visitor visited a camp to give campers a talk on food hygiene and personal hygiene in camp. ”

From other divisions, we have had reports of the many groups that receive some form of instruction in health matters from the medical and nursing staff. One new enterprise is concerned with the Duke of Edinburgh's Award Scheme and members of the staff of the Shipley, Brighouse, Doncaster and Rotherham divisions have been actively associated with the training scheme.

Another innovation was a talk on first aid to supervisors of school meals canteens.

In an endeavour to keep abreast of the ever changing pattern of the needs of the community, we took advantage of the in-service training facilities provided by the Central Council for Health Education, and members of their staff conducted a two-day course at South Elmsall on "Progress in Health Education" and another one on "Mental Health" at Hemsworth. The latter course was in the nature of a follow-up of one held earlier in the year at Grantley Hall and is reported in the health visiting section. One of the most valuable aspects of these courses lay in the general discussions that took place each afternoon because it was then that the staff were able to discuss problems related to their daily work and, in the light of the knowledge gained during the morning sessions, to attempt to find solutions. At South Elmsall, health education materials were displayed, whilst at Hemsworth emphasis was laid on the subject of mental health by a series of pegboards depicting the services of care and after-care.

During 1962, the demand for materials for home safety exhibitions increased considerably and the stands available from central office have been displayed in most areas of the County, either in clinics or at special exhibitions. In Skipton, Brighouse, Kirkburton and Ossett the exhibitions were staged in halls in conjunction with the police road safety exhibits, whilst at Emley, Penistone and Wetherby they were housed in marquees and included in the agricultural shows. The following extract from the Wetherby News, dated 15th June, illustrates some of the valuable aspects of staging these exhibitions where there is a ready audience, many of whom do not attend clinics, schools or other such institutions:—

"The Divisional Medical Officer of Health, Dr. R. G. Smithson, was pleasantly surprised by the interest created by the home safety exhibition—an innovation for Wetherby Show. There was a steady stream of visitors of all ages throughout the day to see a number of 'Make it Home Safe Home' exhibits. These began with illustrated advice to mothers with young babies to provide a firm pillow, safety harness and cat net for the pram. Nearby were examples of non-inflammable material for both children's and old people's clothes. Material of this kind can be obtained locally, it was explained, at a cost of about one-third more than untreated material. The dangers of falls in the home through worn or badly fitted carpets were graphically illustrated together with the care needed to ensure that electrical appliances were in safe working order. In the centre of the marquee was a varied display of the easy ways in which a serious fire can be started in the home. Also on view were the special fireguards supplied by Wetherby Rural Council to old people and to handicapped persons. Specially designed for the handicapped was a gas cooker with safety knobs and controls and incorporating a simple device for holding pan handles in position.

Many of the safety in the home hints offered in the exhibition were also touched upon in a delightful puppet show given by two members of the divisional health staff, Miss Catherine Swift and Miss Thelma Webb.

A film on smoking and lung cancer was also shown."

Dr. Ward, Divisional Medical Officer (Colne Valley), received the following letter of appreciation from the Denby Dale Urban District Council:—

"The Home Safety Committee extend their warmest and sincere thanks for the marquee and the display which you provided on the occasion of the Emley Show in August.

The Home Safety display was an unqualified success."

The puppets continue to provide a useful method of arousing interest and imparting knowledge of health education subjects. One of the most original puppet shows was held in Stainforth clinic in connection with the opening of the local swimming pool. The puppets depicted the water safety code and also stressed the need for gradually increasing periods of exercise such as playing tennis and swimming, and also sunbathing. In conjunction with this effort, there were pegboard displays advising on the prevention of poliomyelitis and summer accidents.

In addition to a two-day mental health exhibition held at Goldthorpe, a display of the various materials available for use in the health education field was arranged in County Hall in September for the information of Council members. Owing to the lack of technical assistance it was necessary to borrow stands for this occasion from the ambulance service and we are grateful to Mr. Whitaker for his assistance.

The demand continues for talks to be given by various members of the staff on a miscellany of subjects to varied groups often holding meetings at weekends or in the evenings. Most members of the staff have given willingly of their free time but in some cases saturation point has been reached because the preparation of talks and visual aids requires much time and often research, and when this is added to the time needed for giving the talk and probably travelling, the total can add up quite considerably. Nevertheless, health education programmes are gradually expanding to include a greater proportion and a wider age range of the community. There is, of course, still a great deal to be done.

Recuperative Home Treatment:

Four hundred and twenty-seven applications for recuperative home treatment were received as compared with 435 in the previous year. One hundred and thirty-four cancellations represented 31·4 per cent. of the applications, and, of the remainder, 293—86 men and 207 women (4 with children)—were admitted to one or other of the under-mentioned homes.

Binswood Short Stay Rest Home, Didsbury, Manchester; Blackburn and District Convalescent Home, St. Annes on Sea; Boarbank Hall, Grange over Sands; Brentwood Recuperative Centre, Marple, Cheshire; Spero Holiday Scheme; Elizabeth Fry Home, York; Evelyn Devonshire Convalescent Home, Park Hall, Buxton; Hunstanton Convalescent Home, Hunstanton, Norfolk; Metcalfe Smith House, Harrogate; Semon Convalescents' Home, Ilkley; Shoreston Hall, Seahouses, Northumberland; Tudor Convalescent Home, Bridlington; Yorkshire Foresters' Convalescent Home, Bridlington.

Seven of these homes, which together accounted for 87 per cent. of admissions were inspected during the year. Standards and facilities available naturally varied from one home to another but were generally satisfactory, although it was noted that most of the accommodation was in multi-bedded rooms giving little privacy for individual patients. In one case, the number of beds per room was reduced as a result of the visit, and a consequent adjustment in maintenance charges agreed. The use of another home was discontinued when, following the investigation of complaints received, it became obvious that it was being used mainly for convalescent holidays for employees of industrial undertakings and the environment was not suitable for the general type of convalescent patient dealt with under the Authority's scheme.

Difficulties were experienced in obtaining vacancies for certain types of patient, mainly aged persons and patients unable to climb stairs, although—as

a result of the visits of inspection—two homes agreed to raise their age limit during the winter months.

The County Council have agreed in principle to the acquisition of premises suitable for adaptation for use as a convalescent home and, at the end of the year, enquiries were being made into properties available at St. Annes on Sea.

Provision of Nursing Equipment in the Home:

15,159 items of nursing equipment were issued to patients being nursed in their own homes, a decrease of 137 over the 15,296 items issued in 1961. The following schedule shows the wide range of equipment which is now made available.

Item	Number on loan	Number available for issue	Total	Number of issues during year
Bath lift	—	1	1	—
Bath seat	2	2	4	4
Bedding: blankets, pillows and cases, sheets, etc.—pieces	1,043	275	1,318	1,145
Bed blocks	8	147	155	39
Bed cradles	233	117	350	508
Bed pans	984	664	1,648	2,959
Bed rests	460	264	724	1,079
Bed tables	5	12	17	10
Bedsteads: hospital, with self-lifting pole, and other	227	22	249	342
Chairs: geriatric, relaxing, high rest, "Amesbury" play, stairway (carrying) etc.	19	12	31	28
Colostomy sets	2	6	8	2
Commodes: chair and other	364	3	367	655
Cushions: air and "Dunlopillo"	33	12	45	42
Enuresis alarms	220	1	221	561
Fracture boards	37	5	42	51
Hemiplegic Exercisers	3	1	4	4
Hot water bottles	9	88	97	25
Ileostomy sets	2	3	5	4
Lifting hoists	17	1	18	21
Lifting pole and chain	11	4	15	15
Mattresses: air, biscuit, "Dunlopillo," hair, water, "P.C.P.," spring-interior	315	31	346	470
Open-air shelters	6	6	12	12
Pressure rings: air and foam rubber	556	630	1,186	1,536
Rubber/plastic sheets	999	538	1,537	2,616
Sputum mugs	36	259	295	67
Urinals: male and female	592	721	1,313	1,509
Walking aids: 'Amesbury,' 'Bonaped,' 'Zimmer,' 'Companion,' crutches, tripod, walking sticks	384	168	552	515
Wheel chairs: bath, folding, junior, self-propelled, spinal, stairway, etc.	400	55	455	839
Miscellaneous: feeding cups, steam kettles, breast pumps etc.	38	79	117	101
	7,005	4,127	11,132	15,159

Laundry Service for Incontinent Patients:

At the end of the year, six Divisional Medical Officers were operating a laundry scheme for incontinent patients, but in only two of the Divisions concerned can the service be regarded as being fully operative. Due to geographical and other difficulties, it is not likely that it will be found possible to extend this service to many additional areas.

The following report has been submitted by Dr. Battersby, Divisional Medical Officer (Shipley):—

“ During 1962, the number of cases covered by the laundry service was 53. The average number of cases covered per month was 10, and the number of new cases covered during the month was 4.

Delivery and collection was twice weekly—Tuesday and Fridays. The laundry is packed by the cleaner on the previous evening prior to delivery. Delivery time is approximately 2 hours and the approximate mileage covered per delivery is between 20 and 30 miles.

The laundry service in the main works well and patients and relatives seem grateful. We have had excellent co-operation from the driver of the van.

However, one or two difficulties have been experienced. This is not in reference to the draw sheets which are always of value. The two difficulties which have been experienced are—firstly, where the patient is nursed in a double bed with single sheets, these have not always been adequate; secondly, where flannelette sheets have been requested because the patient has always used this type of sheet.

My personal opinion, however, is that it would not be practical to have flannelette for this service and these occasional instances do not warrant the additional expense.

Thornton View has co-operated well in dealing with the laundry and there have been no major problems. Clean linen has always been returned in good condition, and there has been no staining of the draw sheets in spite of the twice-weekly collection when some soiled linen must remain dirty for three days.”

An alternative service is that of providing disposable pads for the incontinent, and this provision has expanded rapidly since its introduction during 1961. The service is much appreciated by the patient, relatives, and the home nurse. In addition to supplying pads for use by the patient in bed, protective pants with disposable pad inserts are now available for the ambulant incontinent patient.

Liaison with the Hospital Service and General Practitioners:

During 1962, the Ministry of Health was concerned with creating a better liaison between hospitals, general practitioners and the local health authority services, the chief aim being to reduce hospital waiting lists by caring for the patient at home whenever possible, either by early discharge from hospital or by giving domiciliary care to cases which could be treated at home. These decisions do not rest with the local authority but with the general practitioner and the hospital medical staff but, after decisions are made, then liaison with local authorities becomes necessary. There are many ways of practising good liaison work. In the West Riding, many methods have been tried according to the type of hospital and the need. No health visitors are doing liaison work only; they have, in addition, a health visiting area which keeps them up-to-date with present-day trends, which is very necessary to anyone doing this type of work.

The work varies from those attending case conferences relating to discharge of patients to those who do a round with the consultant. There are also health visitors who attend the general hospitals weekly to ascertain who is being discharged and whether they need help. Much good liaison is also being done between the hospital almoner and the divisional office personnel. In spite of this, there is room for improvement and this could probably be effected by having one liaison officer within each division.

GERIATRICS:

The work in this field is inevitably growing and the more the health visitors do in this branch of the work the more they realise the real need for contact

with the aged. The health visitors doing this work have many social problems to solve, and it is in this sphere that they find the work so worth while.

Mrs. L. Laceby, health visitor/liason visitor in the Morley Division and attached to Headlands Hospital, Pontefract, has sent in this report:—

“ *Analysis of Visits*

During the period April to December, 1962, a total of 205 visits was made as follows:—

Sex	Age Groups					
	50+	60+	70+	80+	90+	Total
Male	3	8	19	21	3	54
Female	1	—	62	85	3	151
Totals	4	8	81	106	6	205

General Observations

- (a) The high percentage of elderly people living alone is a matter for some concern. Very few are capable of fully preparing their own meals, and it follows that there must be a considerable amount of undernourishment leading to ill health. An extension of the ‘ Meals on Wheels ’ Service to all areas would go a long way towards solving this problem.
- (b) The retirement and supplementary pensions appear to provide sufficient finance but, in cases where the patients have been ill for some time and are living alone, there must—of necessity—be personal neglect and a deterioration of living conditions due to no contact having been made with the available services.
- (c) The number of instances where relatives of patients state that they are unable to give any assistance or care appears to be increasing. The reasons put forward seldom differ between cases. Most common in the general pattern of reasons are:—
 - Working hours allowing no available time.
 - Personal health reasons.
 - Family commitments.
 - Travelling distance.

I find this necessary work most interesting, rewarding and worth while.”

Dr. Douglas, Divisional Medical Officer (Spenborough), reports:—

“ All admissions to geriatric beds are visited by the health visitors who provide home reports for the consultant geriatrician and recommend to him degrees of urgency of admission. The close relationship between the various hospital almoners and the local health authority staff has continued to be excellent.”

Dr. Ferguson, Divisional Medical Officer (Doncaster), also states:—

“ The Divisional Nursing Officer visits the Geriatric Unit as often as possible, on an average each week, but is in constant telephone communication with the Secretary.

Almost every old person or chronic sick patient for whom application for admission is made is visited by the health visitor and an assessment made as to the urgency of the case. Reports and recommendations are made. Every co-operation is received from the staff of the hospital.”

Dr. Paterson, Divisional Medical Officer (Castleford), writes:—

“ During 1962, an excellent standard of liaison was maintained between the departments concerned with the care of the geriatric patient. Every Wednesday morning, the liaison health visitor attends a case conference at the Headlands Hospitals, Pontefract, during which the progress of each individual patient is discussed with the Geriatric Consultant

with a view to their ultimate discharge. At these conferences, the health visitor is able to go into case histories in both breadth and depth and can advise on home circumstances. Upon their discharge, certain of the patients who would be expected to derive benefit from such a course, are encouraged to return to the hospital twice a week from 9-00 a.m. to 4-00 p.m., during which time they are supplied with meals, are given treatment where necessary and are encouraged to attend for remedial and recreational therapy. Up to August, 1962, there were two specialist health visitors carrying out this work, but subsequently, owing to the resignation of one of them, it has to be done by one.

Approximately two years ago, a patient, who was an aged person living in Castleford, was afflicted with a complaint which resulted in a complete paralysis of both lower limbs, and ultimately she was transferred from the Pontefract General Infirmary to the Geriatric Unit before returning home. As a result of the close co-operation between the Consultant Geriatrician and the local Medical Officer of Health, the latter brought the case to the notice of the local Housing Committee during 1962, and the patient, who is determined to fend for herself as much as possible, has now been re-housed into accommodation much more suited to her physical condition. Special equipment is being installed in the house to enable her to become still more independent.

This case is typical of many who are daily being assisted due to the liaison existing between the hospitals and health department staff in this division.

During the year, the liaison health visitor(s) made a total of 525 visits."

From Dr. Burn, Divisional Medical Officer (Horsforth), comes this report:—

"The health visitor attached to St. Luke's Hospital attended 37 sessions there and one at Thornton View (Part III accommodation)—a total of 40 hours' duty. Three requests for background reports were made and dealt with. Twenty-six patients were referred for after-care and all were dealt with. In twenty, the difficulty was solved by provision of home help. Ten patients were interviewed in hospital and, of these, one case was settled before discharge and the remaining nine by follow-up after discharge. Service was provided in one case where an environmental report was required. Relationship with general practitioners and hospital medical staff is good."

These reports sent in by Divisional Medical Officers show an excellent relationship between local authorities and hospital staffs, and there is a need for this to grow in other hospitals.

DIABETICS:

The follow-up and after-care of diabetic patients has not progressed over the County, but the number of cases has increased where this work is being carried out.

In Division No. 20, where this scheme first started, the work has expanded and Dr. Ward, Divisional Medical Officer, has sent in the following report:—

"It has been our ambition to have a complete register of all diabetics in the division, but, every now and again, we are brought up to a sharp realisation of the fact that practice must, of necessity, take precedence over perfection when we discover quite by chance, and for the first time, a diabetic of many years' standing. The death certificate is another very-revealing mine of information, alas coming too late for us to take any active interest whatsoever in the matter.

The local diabetic consultant has given his blessing to our district service and furnishes this department with every assistance possible in the follow-up of diabetic patients. The liaison between the district health visitor and the hospital sister in charge of this department is very close indeed; they meet 'officially' once per month to discuss cases of interest and in emergency any time during the month. In this way, the advice given in hospital as regards diet and insulin regime can be verified by the liaison health visitor on the district and any divergence on the part of the patient from the artificially-set norm can readily be checked and not infrequently rectified.

One baffling case came to our notice of a patient who, in spite of sticking rigidly to her diet and insulin administration, infrequently manifested a trace of sugar in her urine. It was eventually discovered that she was in the habit of eating tinned peas, and the preserving solution in which these peas were kept contained a fairly high glucose content. Now this patient eats tinned peas no longer.

In addition to the adult diabetics, we have a girl aged 14 and two boys, one aged 8 years and another 14 years. All three have come to accept their disability with equanimity. In the case of the boy of 8, the mother gives the injections, but the boy of 14 gives his own injections.

Whether one is dealing with an adolescent or an adult, a woman in pregnancy or an aged person, the work is most absorbing and satisfying and the fact that the frailties of human nature, as regards diet and insulin, can surely be guided along the proper channels provides its own reward to the health visitor doing this work.

The liaison health visitor is often able to give invaluable advice regarding how to obtain a special diet allowance through the National Assistance Board, to advise chiropody treatment in the cases of old persons, and—in conjunction with the hospital—to arrange for the provision of food-weighing scales."

In other areas there is some liaison, as in Todmorden and Brighouse where they share the attendance at the special clinic, taking six months each. This service is done by the district nurse and she attends alternate weeks with a person from the Halifax County Borough.

MATERNITY:

There does seem to be some improvement in liaison between maternity hospitals and local authorities, either by telephone or by direct contact, though sometimes insufficient time is given for a report to be obtained on home conditions.

Dr. Caithness, Divisional Medical Officer (Batley), reports:—

"Fulllest co-operation is maintained with Batley Maternity Home and the Matron, apart from routine notification of discharges direct to this office, also reports direct on any cases considered to need special supervision following discharge from the home.

In the case of Staincliffe Hospital Maternity Wing, there is direct contact between hospital and midwife in the cases of early discharges."

From the reports which have come in from Divisional Medical Officers, it appears that the most effective liaison is by personal contact, and Dr. Paterson, Divisional Medical Officer (Castleford), has this to say:—

"The liaison service worked in conjunction with the Castleford Maternity Home continues to be an accepted feature of the community life, and Matron and her staff are coming more and more to rely on the services of the liaison health visitor attached to the Home who, in turn, is assisted by the district health visitors to obtain vital information relative to the patients and their home conditions."

From Dr. Burn, Divisional Medical Officer (Horsforth), comes this report:—

"Forty-eight sessions have been undertaken at Four Gables Maternity Home, a total of 24 hours' duty at the Home. Assistance was provided for 58 patients. Sixteen of the mothers were referred to midwives on discharge, and all were eventually referred to the health visitor. There were 54 deliveries in connection with cases seen and, of these, 20 were not more than 5½ lb. weight at birth and the remainder were more than 5½ lb. Six of the infants were born with handicaps as follows:—

- 1 hare lip.
- 1 hare lip and cleft palate.
- 1 heart lesion.
- 1 mongol.
- 1 blind, with malformation of bones.
- 1 spina bifida (died in Leeds Maternity Hospital).

The visits include discussion with Matron regarding forthcoming discharges. This is reported to the Divisional Medical Officer."

PREMATURE BABIES:

There seems to have been an increase in liaison work in various parts of the Riding.

Dr. Ward, Divisional Medical Officer (Colne Valley), reports:—

“ *Huddersfield Royal Infirmary*

Pædiatric and Maternity: Premature Babies.

A health visitor visits the hospital weekly and does a ward round with the Pædiatric Consultant and Ward Sister, who discuss cases to be discharged with her. This information is passed on to the health visitor on whose district the child lives, and the case is visited, advised and kept under supervision if necessary. The same health visitor also visits the maternity ward at the Infirmary and sees Sister, who tells her of any special points in connection with premature babies or mothers and babies who are due to be discharged shortly. This information she again passes to the appropriate health visitor.

Time taken—approximately 2 hours weekly.”

Miss J. Hough, Health Visitor, Morley, reports on the work started in October, 1961, with Manygates Maternity Hospital and the County General Hospital:—

“ This liaison work started in October, 1961, when arrangements were made for me to visit these hospitals once a week. I obtain details of new babies, ring the health visitor concerned, who advises me details of the home conditions, i.e., type of house, cleanliness and maternal efficiency, plus any other relevant information which I pass on verbally to the Pædiatrician or the Sister-in-Charge of the unit when the baby is nearing the time for discharge home. I also ring Manygates Hospital when I know there will be babies ready for home, so I can let the health visitor know the actual date.

Dr. Roberts is the Pædiatrician at the County General Hospital, and Dr. Morgan was the Pædiatric Registrar until he left this area recently to take up another appointment.”

Dr. Paterson, Divisional Medical Officer (Castleford), reports that he has found the arrangements made with Miss Hough and his own liaison health visitor to be most helpful; he states:—

“ The home conditions and environmental reports are frequently obtained prior to the discharge of the baby from the hospital, and this service has greatly improved during the last year.

It can be said with truth that all the health visitors have found it a most useful and helpful service.”

CHILDREN:

Liaison in this branch of the work is much the same as before, the greater part of liaison work being done between the Divisional Medical Officer and the Pædiatrician.

SPASTICS:

In Castleford, there is a good liaison with hospitals regarding spastics, and Dr. Paterson has sent in this report:—

“ No. of known cases on our register:

No. of adults in Division	...	...	...	...	...	38
No. of children in Division	...	...	...	...	...	58
Domiciliary visits carried out in the Division	...	...	...	...	...	136

Since not a few of these spastics lead an active life with varying degrees of normality, they do not all require the same amount of attention and supervision as many who are inactive and unable to follow a normal school life, etc. Under these circumstances, selective visiting must, of necessity, prevail since it would be futile to endeavour to supervise those who can fend for themselves and, furthermore, they all know where to apply for advice, etc., should it be needed.

The work involved in visiting these spastics is extremely interesting and absorbing, and it is palpably noticeable that, where advice is sought and given, the service is much appreciated.

It has been found that the movements involved in swimming have a definite therapeutic effect on cases of this nature, and swimming lessons were introduced during the year at the Wakefield baths. Selected cases were given free transport by ambulance and the scheme looks as if it could be a real success.”

CHEST:

Liaison in this service is quite good. Health visitors and specialised tuberculosis nurses visit clinics for this specific service. In Division No. 26, however, a health visitor visits Wath Wood Hospital, and Dr. Cusiter, Divisional Medical Officer, has sent in this report:—

“ Once again, I have spent a very happy year visiting Wath Wood Hospital. I am most grateful for the help given by the hospital staff.

Work performed by the health visitor during the year 1962

Number of visits to hospital	47
Number of interviews in hospital	242
Number of home visits... ..	5
Number of investigations of home conditions	219
Number of cases for supervision by health visitor on discharge	53
Number of home helps arranged for patients on discharge...	4
Number of cases for special environment investigations ...	3

The trend of work has altered at Wath Wood Hospital. Thirty-five beds have been closed during the year so that structural alterations may be carried out. Even so, there have been more admissions. There have not been so many ‘ long-stay ’ patients, but there have been more short-stay non-tubercular chest cases admitted for investigation, bronchoscopy, etc.

Cases of Interest

Female patient aged 49 years—Pulmonary Tuberculosis. This patient is divorced but receives no maintenance. She had been working as a housekeeper and her 15 year old daughter was living with her. The daughter is a weaver and had gone into lodgings whilst her mother was in hospital. The patient had been in Wath Wood on a previous occasion in March, 1960. As she was very upset about her financial position, I rang the National Assistance Board and they told me that, as long as the patient was in hospital, her rent would be paid, and she would have a National Assistance Grant of 16s. 6d. per week. I was able to tell her this right away.

Female patient aged 19 years—Pulmonary Tuberculosis. This patient had previously had a tuberculous kidney removed in Doncaster Royal Infirmary. Her husband is a miner and she had an eight months old baby. The family had been from one lodging to another. Neither the patient’s family nor her husband’s family were at all helpful. They were on the housing list. This matter was discussed with the Medical Officer of Health, who was successful in his application for the re-housing of this patient on her discharge from hospital.”

Chiropody Treatment:

There has been no major development in this service during the year. The scheme, introduced in February, 1960, experienced a rapid expansion during 1961, which developed into a moderate one in 1962.

The service remains as one partly administered through the agencies of the various voluntary associations in the County and partly administered directly by the County Council. No change in this pattern is envisaged until such time as the national registration of chiropodists is completed, when it may be expected that some voluntary associations will wish to hand over the service for direct administration by the County Council.

By the end of the year, there were 112 voluntary associations taking part and, in addition, a direct service was available at 62 clinics and at the premises of 20 chiropodists.

The total number of patients treated during the year was 34,962 compared with 31,526 in 1961 and 19,918 in 1960, and the total number of treatments given was 162,032 compared with 141,410 in 1961 and 69,439 in 1960.

Of the 34,962 patients treated, 34,052 were in the aged category, which represents some 14·8 per cent. of the estimated population of men over sixty-five years of age and women over sixty. When the scheme was first established, it was thought from the evidence available that the service would probably eventually cover some 15 to 20 per cent. of the aged population, and the figure of 14·8 (13·3 in 1961) gives some support to this belief. The pattern varies widely, however, over the County as a whole and it is obvious that, in some areas, a considerable expansion in the service can be anticipated, probably when there is an improvement in the availability of suitably-qualified chiropodists. In the Skipton, Keighley, Brighouse, Barnsley, Wath and Thorne Divisions, the percentage of the aged receiving treatment in 1962 was 23·4, 24·4, 26·4, 23·0, 21·3 and 20·2 respectively, whereas in the Horsforth, Harrogate, Goole and Pontefract Divisions, the percentage was as low as 3·9, 5·6, 6·5 and 5·4 respectively. In seven Divisions, the percentage was between 10 and 15 and, in six Divisions, between 15 and 20.

Domiciliary treatment is provided, where necessary, on medical grounds and the extent to which such treatment was given in 1962 is causing concern in some areas where there is a tendency for this more costly type of treatment to increase. Again, the pattern varies widely in the County as a whole, and every effort is being made to ensure that this form of treatment is restricted to patients who are incapable of attending for treatment at a convenient centre.

During the year, a new rate of payment for chiropodists undertaking treatment in their own surgeries was notified to authorities by the Whitley Council. This provides for payment at the rate of 7s. 6d. per treatment. This brought to an end the arrangement which the Authority introduced at the inception of the scheme of a notional sessional rate which had been paid to the chiropodists for a total of nine treatments.

The following is a statistical summary showing the extent to which treatment has been given during the year under the agencies of the voluntary associations and directly by the County Council.

		<i>Voluntary Association Schemes</i>	<i>Direct Service by County Council</i>	<i>Total</i>
Number of sessions held:				
In voluntary association premises	...	4,182	—	4,182
In clinic premises	... ... ... ...	—	3,659	3,659
		<hr/>	<hr/>	<hr/>
		4,182	3,659	7,841
		<hr/>	<hr/>	<hr/>

					<i>Voluntary Association Schemes</i>	<i>Direct Service by County Council</i>	<i>Total</i>
Number of patients treated:							
In chiropodists' surgeries:							
Pensioners	...	...	...	...	10,038	2,489	12,527
Physically handicapped	...	...	...	...	100	91	191
Expectant mothers	...	...	...	...	8	14	22
In voluntary association or clinic premises:							
Pensioners	...	...	...	...	7,028	6,257	13,285
Physically handicapped	...	...	...	...	118	79	197
Expectant mothers	...	...	...	...	8	13	21
Domiciliary treatment:							
Pensioners	...	...	...	...	4,833	3,407	8,240
Physically handicapped	...	...	...	...	249	225	474
Expectant mothers	...	...	...	...	4	1	5
Total number of patients treated	...	...	...	...	<u>22,386</u>	<u>12,576</u>	<u>34,962</u>
Total number of treatments given:							
Pensioners	...	...	...	...	100,262	57,981	158,243
Physically handicapped	...	...	...	...	1,813	1,890	3,703
Expectant mothers	...	...	...	...	26	60	86
					<u>102,101</u>	<u>59,931</u>	<u>162,032</u>
Number of patients treated per session:							
					7.7	8.2	7.9
Percentage of total patients treated receiving domiciliary treatment							
	...	...	...	...	22.7	28.9	24.1
Percentage of aged population receiving treatment (men over 65 years and women over 60 years)							
	...	...	...	...	9.5	5.3	14.1

DOMESTIC HELP

The establishment for the year was 1,050 equivalent whole-time domestic helps, having been increased from 1,000 on the 1st July, 1961. This is a service in which it is most difficult to forecast even the immediate future need and no estimate can be given of what the eventual establishment will need to be to meet the full needs of the community. The domestic help service is one in which many influences are at work—the increasing number of old people in the community, the trend towards earlier hospital discharge by providing more community care services, the desirability of keeping the aged in their own homes as long as possible, epidemic sickness, abnormally severe winters—and anything approaching accurate forecasting is impossible.

Having regard to the then current demand, it was not anticipated that it would be necessary to increase the overall establishment of 1,050 until the financial year 1964/65, but, towards the end of 1962, there was a sudden spurt in demand for the service and the indications at the end of the year were that it would be necessary to seek an increase for the year 1963/64. In practice, the service is one provided mainly for the aged and chronic sick, and the number of cases in this category receiving assistance rose from 8,512 at the 31st December, 1961, to 9,201 at the 31st December, 1962.

Over the year as a whole, the equivalent of 1,009·5 whole-time domestic helps was employed compared with 954·6 for 1961 and 914·7 for 1960. Fifteen thousand four hundred and twenty-eight cases received 2,204,792 hours' help through the service, an increase of 958 cases when compared with 14,470 cases in 1961. The help provided for the aged and chronic sick represented 79·0 per cent. of cases (1961—77·5 per cent.) and 85·0 per cent. of the total hours (1961—84·1 per cent.).

<i>Classification of Cases Assisted</i>						<i>No. of Cases</i>	<i>Hours employed</i>
Maternity	...	...	...	...	...	1,161	68,234
Tuberculosis...	...	...	...	...	...	102	14,964
Chronic sick (a) aged 65 or over	...	...	...	...	...	12,185	1,874,499
(b) under 65	...	...	...	...	...	1,263	178,374
Other...	...	...	...	...	...	717	68,721
Totals						15,428	2,204,792

Problem Families:

Although provision was made in 1961 for selected domestic helps to be employed in the rehabilitation of problem families without charge to the recipient of the service, little use has been made of this provision by Divisional Medical Officers. Each case required approval from headquarters and subsequent confirmation by Committee. During 1962, wider discretion was given to Divisional Medical Officers who now can, in conjunction with the Co-ordinating Committees, employ domestic helps on this work up to a certain maximum number of hours per case. This greater freedom may lead to domestic helps being used to a greater extent than hitherto in rehabilitation work.

MENTAL HEALTH

The pattern of the Mental Health Service has become more firmly established during 1962 and there has been an increase in integration with the Hospital Psychiatric Services and those of the General Practitioners. Mental Welfare Officers are increasingly being allowed to enter the hospitals to see patients and regular case conferences are now held at all large psychiatric hospitals. There have again been difficulties in staffing completely the Mental Health Areas, Storthes Hall still being one of the more unfortunate areas but it is hoped that early in the New Year as a result of additional appointments the establishment of 46 Mental Welfare Officers will be complete. A recent survey of Divisional Medical Officers shows already a demand for an increased establishment and this will be looked into in the New Year with a view, if possible, to providing more officers in those areas where the need is considered to be the greatest.

During the year the training programmes for Mental Welfare Officers and Staffs of Training Centres have been continued as in previous years and these have been found to be valuable in widening the experience and knowledge of the officers concerned. The activities at the out-patient clinics have increased thus forming a strong link between the patients, General Practitioners, Hospital and Local Authority Services and the Consultants are using the services of the Mental Welfare Officers to an increasing extent in respect of community care.

Two new Training Centres were opened at Harrogate and Horsforth. Both are Comprehensive Centres providing training for children, men and women and a special care unit for patients physically and mentally handicapped who are considered unsuitable for training in either of the other departments.

There is still difficulty in obtaining urgent places in hospital for the subnormal and severely subnormal but this is likely to be a problem for some years to come. There has been considerable help to parents by a continuation of the short stay care service which is of extreme value in allowing a patient to have a change from his home surroundings and at the same time giving some relief to the family. On occasions it has not been possible to obtain a short stay place when required but this instance is in the minority. In fact, short stay care has been provided in the hospitals for 169 patients during 1962.

There has been an increase in the number of psychiatric social clubs and the Mental Welfare Officers have reported the progress made by some of the members of the clubs which have been established longest. This type of club is likely to be one of the strongest links in the community service and credit is due to the Mental Welfare Officers who spend so much of their time attending these clubs every week and also their success is in no small part due to the voluntary effort by the Senior Mental Welfare Officers.

Training of Mental Welfare Officers:

The National Association for Mental Health again promoted courses for Mental Welfare Officers and seven Officers with at least two years' experience attended a Refresher Course. This course is held in three parts commencing in September and being residential for four weeks, the second part consists of 20 weekly case work seminars and the third part is residential lasting for a week and will be held in March 1963. The tutor on this course is Mrs. Farrow, the County's Psychiatric Social Worker-Tutor in the Mental Health Service and there is thus a strong link with this course and the in-service training

provided as part of the Mental Welfare Officer's training programme. The aim of the Refresher Course is to widen the understanding and improve the skills of the students attending and covers lectures on the following subjects:- human development, the nature of mental illness, social and clinical aspects of mental subnormality, sociology, legislation, principles of social case work, rehabilitation group work and seminars.

Two officers newly appointed to the Mental Health Service attended an Induction Course in Harrogate from the 5th to the 16th March, 1962. This course is specifically designed for new entrants into the Mental Health Service and is aimed at helping the new Mental Welfare Officer to orientate himself in his job. The course content includes lectures on sociology, psychology, mental subnormality, human development, the helping process and the worker/patient relationship. Visits of observation are also included and there is provision for guided discussion and seminars.

Two Senior Mental Welfare Officers attended a residential course in Harrogate from the 5th to the 16th February and from the 30th April to the 4th May and one Senior Mental Welfare Officer attended a two-day in-service training course in mental health conducted by the Central Council for Health Education in conjunction with the National Association for Mental Health at Sheffield during March 1962. Six short residential training courses were held at Grantley Hall, near Ripon and these were specifically designed for mental welfare officers some of whom also attended a joint course with health visitors to promote mutual understanding and co-operation. This course was of particular benefit and interest to all as it was a means of bringing together and strengthening the ties between the health visitors and the mental welfare officers and giving them greater understanding of each others functions.

The teaching groups for mental welfare officers became well established during the year and seven groups are now held on one afternoon per fortnight covering all officers in small groups. The aims of these groups are the teaching of basic principles and practice of social case work and professional attitudes by the seminar method using workers' own case material for this purpose. It is hoped to achieve an integration of the theory taught at Grantley Hall and on National Association for Mental Health Courses with their practical work. These groups also provide for personal supervision or consultation, especially for the newly appointed workers or for those who may experience special difficulties.

Case conferences have been established and are held monthly at the seven main psychiatric hospitals. The main purposes of these conferences are to provide teaching facilities and to promote closer co-operation between the hospitals and local authority workers (the psychiatrists, hospital social workers and nurses, mental welfare officers and representatives of other social agencies attend).

The County Council have also approved in principle that suitable officers of the Mental Health Service be seconded to attend special two year and one year courses for experienced Mental Welfare and Child Care Officers. The two year courses some of which will be held in Leeds are designed to meet the urgent need for further trained staff by providing training in which the standard of theory and practice will be closely linked. The special one year courses are organised by the National Institute for Social Work Training and will be full time and will include attendance for two further periods totalling two weeks after the first 12 months course. Applications for these courses have already been made by certain officers.

It has also been agreed that a Psychiatric Social Worker's Certificate may be regarded as a suitable and appropriate qualification for Mental Welfare Officers and approval in principle to two suitable officers being seconded to attend the above course in Psychiatric Social Work training commencing during the year 1963/64 has been given. The fees and travelling expenses of the above courses will be paid and financial assistance afforded in accordance with the scheme approved by the County Council in July, 1961. The external Diploma in Social Studies has also been approved for inclusion in the list of approved post entry training courses which may be undertaken by Mental Welfare Officers.

Training Centres for the Mentally Subnormal:

At the end of the year new comprehensive training centres had been opened at Harrogate and Horsforth for 86 patients each. The Horsforth (Junior) Centre was to be retained and used for patients under the age of 11 years. The erection of the proposed centres at West Ardsley, Kirkburton and Rothwell was well advanced as also was the new adult accommodation to be provided at the existing Centres at Airedale (Castleford), Ecclesfield, Hemsworth, Keighley and Maltby. New adult accommodation had been added to the Wath upon Dearne and Adwick le Street Centres and was in operation before December, 1962, and additional places had been created at The Gables, Wombwell, by structural alterations within the existing building. The planning of centres to be erected at Skipton and Brighouse had commenced although there had been considerable difficulties in acquiring suitable sites in both areas.

The following is a list of the training centres in operation at the end of 1962, with details of the places provided and proposed:—

<i>Centre</i>	<i>Places</i>	
	<i>Present</i>	<i>Proposed</i>
Adwick le Street	98	—
Airedale (Castleford)	76	104
Brighouse (Junior)	27	—
Ecclesfield	76	95
Harrogate	86	—
Heckmondwike	68	—
Hemsworth	43	100
Horsforth (Junior)	27	—
Horsforth (Comprehensive)	86	—
Keighley	50	100
Maltby	76	104
Ossett (Junior)	27	—
Rawcliffe	86	—
Wath upon Dearne	76	100
Wombwell	35	100

Of the 937 places provided at the end of the year 515 were for juniors and the remainder for men and women and special care unit cases. These places had been planned on 25 square feet for each junior place, 40 square feet for adult female places, 50 square feet for adult male places and 35 square feet per place in the special care units. It must be noted that this accommodation was designed on the original notes of the Ministry of Health which have now been amended and rewritten.

Special care accommodation will be provided at all new centres and at existing centres where it is possible. This type of accommodation will cater for the relatively small number of grossly mentally handicapped patients, some with

physical defects, who may well be regarded as untrainable and whose care, unless provided at home, one would normally expect to be provided in psychiatric hospitals. It is hoped by the provision of special care accommodation to be able to help those parents who are willing to look after their handicapped children at home, rather than to ask for their admission to hospital for permanent care, but who will still require some daily relief from looking after them. It is likely that special ambulance-type transport will be required for such cases. The County Council have agreed that in all centres erected in the future full cooking facilities shall be provided. Centres without cooking facilities will be provided with them and, where space allows, a canteen type dining room so that the men and women patients will be able to obtain their mid-day meals at a self-service counter and select the table at which and the companions with whom they wish to dine.

The re-organisation of the comprehensive training centres on industrial lines for the adult patients has gradually been brought into operation during the year. Supervisors have been redesignated as Centre Supervisors and generally have control of the training in the junior wings and an overall responsibility for the internal administration of the centre. Senior Instructors, both male and female have been appointed for the men's and women's wings—either by the promotion of existing officers or by the appointment of experienced instructors from other training centres or from industry.

Several work contracts had been arranged by the end of 1962, mainly for articles required by the County Supplies Department. Small blackboards, modelling boards, sketch pad backs, bean bags, wash leathers, whip stocks and similar products were being made and the production of other articles will be introduced as far as is possible according to demand. The contract work for the County Supplies Department was allocated to as many centres as possible. Immediately, there was a marked increase in their work and improvement in attendance on the part of those men and women engaged in production. Regular supplies of offcut softwoods were being provided at four centres for splitting into firewood for sale to the County Supplies Department and the financial proceeds—less the cost of the wood—was credited to those four centres. Other work was also being undertaken as at the Airedale Centre where the Divisional Medical Officer had been able to negotiate annual contracts with the Castleford Borough Council for the supply of seed boxes and perishable plant pots. At the Keighley Centre patients were dismantling old television sets and from the salvaged parts T.V. sets were to be assembled by the contractor for old people at a very nominal rent.

At the Adwick le Street Centre the County Council had acquired by appropriation from the Civil Defence Service a disused decontamination station and this was being altered internally so that a contract could be undertaken for the production of concrete washers for an outside firm who supply the washers as an essential part of the reinforcements for new roads. When the alteration of the building is completed, early in 1963, the work of production will be commenced.

Arrangements had been made for the articles manufactured to be sold at such a price as would show a profit, after the deduction of material costs, to be credited to each centre and a scheme of incentive or reward payments made to those men and women engaged in the various processes. No charges will be made by the County Council for the provision of essential services. Divisional Medical Officers will no doubt have their own ideas on methods of payment to the workers and their assistance towards the production of a generally acceptable scheme will be welcomed.

It is not anticipated that the men and women engaged in production will become self supporting—or even nearly so—their rewards will depend on their own efforts and on the work which can be obtained for them—but even the smallest payment to a patient at the end of the week, particularly one who has not previously earned anything, is bound to give a boost to confidence and morale. It is hoped that all officers concerned with the Mental Health Service will help as far as they can in trying to obtain contract work for the centres.

TRAINING OF TEACHERS AND INSTRUCTORS:

The in-service training programme for staffs of training centres has been enlarged by an increase in the number of three and four day courses at Grantley Hall and by one or two one day courses, all arranged by the Organiser of Training. The courses have provided specialised training for different groups of officers and there have been visits of observation to schools and hospitals which have been of considerable value.

The programmes of the various courses have been very comprehensive and include inter alia housecraft, physical education, art, handcrafts, religious instruction, speech training, music, gardening and plant propagation, psychology and sub-contract work. The speakers have included Advisers of the West Riding Education Committee in various subjects, a Minister of Religion, a Schoolteacher, the Supervisor of another Local Authority Training Centre, one of the County's Senior Mental Welfare Officers, an Advisory Mental Welfare Officer of the Ministry of Health and a Parks Superintendent of a Local Authority. Their talks and demonstrations have been very well appreciated and we offer our sincere thanks. By special request an exhibition of patients' paintings was held at County Hall when Members of the County Council attended and listened to a most interesting and enlightening talk on the ideas behind the paintings given by Mr. K. D. Thomas, a West Riding Adviser in Art.

The National Association for Mental Health have continued to arrange 12 months' courses of training for teachers and instructors and seven West Riding officers are attending the 1962/63 courses, four on the course at Sheffield for teachers of junior centres and one female and two male instructors on the course for officers engaged in training adults which is being held at Birmingham.

The policy of the National Association for Mental Health has undergone some changes so far as training courses for Training Centre Staffs are concerned. From 1963/64 three types of diploma courses will be organised:

(a) A two year course for young entrants into the training centre service. These applicants will be expected to have obtained at least three subjects at 'O' level in the G.C.E. examinations. This requirement therefore has had an important influence on the type of young person who has been selected for interview for appointment as a trainee in both the junior and comprehensive centres. With the County Council's established policy of a qualified mental health service in mind, all junior applicants must now comply with the educational requirements of the National Association for Mental Health. Applications from West Riding Officers should therefore not in the future be refused on educational grounds. Year by year the demand for places on the Association's courses is growing as more training centres are being opened throughout the country but the requirement of a good G.C.E. standard from trainees wishing to enter the West Riding service has led to a very good type of young applicant being appointed. This augurs well for the future of the service.

(b) The National Association for Mental Health will continue to run a one year course for Assistant Supervisors as in previous years. This course will cater

for older applicants than trainees and will be for teachers who have had some years experience of teaching the mentally subnormal in training centres or in their own homes.

(c) The third type of course to be organised will be for male and female Instructors who are working in the adult centres or wings. This course is different in character from the course previously mentioned at (b) and will almost entirely be devoted to the different attitudes to be adopted and the different subjects and crafts to be taught to adult patients.

The Organiser of Training attended a week's course for Organisers and Centre Supervisors at Sheffield during the year and a Senior Clerk in the Mental Health Section attended a weekend course at Oxford for officers with administrative responsibilities.

The operation of the comprehensive training centres on the lines recently approved by the County Council, whereby each centre is divided into a junior wing for patients under 16 years of age and two adult wings for male and female patients of 16 years and above was started in September. Teething troubles were expected but there appeared little need to worry about the new arrangement at the end of the year. It may yet be a little early to judge whether the scheme will be completely successful.

GROUP TRAINING:

Due to the opening of training centres, group training has tended to decrease during the past few years and only a small number of classes remained at the end of 1962. The classes at Bentham and Skipton were operating for three days each week but that at the Theosophical Hall, Harrogate, had been closed consequent on the opening of the new centre at Starbeck, and the one at Tadcaster had also been closed. The Kirkburton class will close next year when the new training centre at Kirkburton is completed and patients are transferred. The small classes for a few adults held at Darton, Royston, Wombwell and Worsbrough still continue but these also will be closed when the new adult accommodation is completed next year.

HOLIDAYS FOR PATIENTS:

The holiday venture of last year was repeated in 1962 and approximately 50 patients together with volunteers from the training centre staffs spent two weeks at Whitby from the 18th to the 29th June. The weather generally was good and it would appear that the patients enjoyed themselves and the members of the staff would no doubt regard the venture as a welcome if a more arduous change of duty. The patients enjoyed boat rides, a visit to a zoo, a sports afternoon and trips into the surrounding country and to other nearby seaside resorts. A cine camera was much used and a film in colour of some of the holiday activities has been produced. A smaller party of 20 patients were on holiday at Orton Park, Carlisle, from the 20th to the 31st August. This was also a very happy holiday and one to be repeated. Some of the patients from Health Division No. 19 (Todmorden) who attend the training centre at Stansfield View Hospital, Todmorden, were included in a large party of hospital patients who went on holiday to Skegness. They were in the care of hospital officers and enjoyed their holiday away from home. These holiday schemes are likely to be arranged again in 1963 and I would like to express here my thanks to the hospital officers and our own officers who helped so much to make the ventures successful.

Patients in employment:

A return from Divisional Medical Officers shows that at the end of the year 1,317 patients, not in attendance at training centres, were in full or part time gainful employment or were suitably and adequately employed in their homes.

Psychiatric Social Clubs:

<i>Club</i>	<i>No. of members</i>	<i>Premises</i>	<i>Meetings</i>	<i>Opened</i>
Skipton Psychiatric Social Club	16	Temperance Hall, Skipton	Fortnightly, Thursday evening	November, 1962
The Glen Psychiatric Social Club	30	Somerset House Clinic, Shipley	Tuesday evening	September, 1961
Morley Psychiatric Social Club	8	Central Clinic, Morley	Thursday evening	January, 1962
Rock House Psychiatric Club, Swinton	20	Child Welfare Clinic, Rock House, Swinton	Fortnightly, Thursday evening	August, 1961
Castleford Psychiatric Club	30	Child Welfare Clinic, Sagar Street, Castleford	Wednesday evening	September, 1961
Normanton Psychiatric Club	18	Child Welfare Clinic, Church Lane, Normanton	Monday evening	May, 1962

Non-County clubs attended by West Riding patients

4 U Club, Halifax	January, 1961
Huddersfield	November, 1962

The formation of Psychiatric Social Clubs has speeded up during the year, and an increasing amount of good work is being carried out at various points in the Riding.

Skipton Psychiatric Social Club

This club opened on the 1st November, 1962, with 16 members. The membership fluctuated because of adverse weather and three patients were re-admitted to hospital but it is felt that the club is very worthwhile in that the members have gradually learned to mix and take part in the various activities. The following are some of the activities enjoyed. Bingo sessions, games evening, demonstrations of Christmas decorations and flower arrangements, New Year Party, holiday slides and talk on continental travel, quiz evening, a play by the Townswomen's Guild and an outing to the pantomime. A very small club for two or three subnormal patients has also been established and meets on one afternoon each week.

The Glen Psychiatric Social Club, Shipley

This club has now been functioning for 16 months and many members have left as they have regained their confidence and have settled back into normal life with the knowledge that club support will be available to them should they require it. The total membership is 30 and the average attendance 20 members. The Club meets at Somerset House Clinic and the move to these premises

proved to be beneficial as there was a more intimate atmosphere and the comfort of a fire during the winter was very pleasant. One or two additional subnormal patients were admitted into membership and there are now 7 of these on the club roll of whom 3 attend a training centre, 2 are working and 2 remain at home. There is a hard core of about 8 members who seem likely to continue to be in need of club support indefinitely. They are immature, dependent, some of them lonely and attendance at the club is the highlight of their week.

Activities which are very varied have consisted of games and competitions, tape recorder sessions, film shows, beetle drives, bingo, record evenings when members have brought records of their own choice and their own machines. Some have given small demonstrations of cake decoration, flower arrangement, basketry and painting. A little pottery decoration has also been undertaken. During the summer an outing which was spoilt by the weather was held to the Dales and a trip to Blackpool illuminations. Through the courtesy of the Blind Welfare Association Committee many members have attended monthly concerts organised by the association. At Christmas there was a very enjoyable Christmas Party with a conjuror to entertain. Each member pays 3d. a week which buys tea and biscuits and many members have brought supplies to help out, particularly if they have been celebrating a birthday. The club is largely self-supporting and has not used the full amount of the County's supporting grant.

The Chairman, Secretary, and Treasurer have been elected from the members and the Treasurer's book is periodically open to "audit". The friendly, relaxed atmosphere has been conducive to the sharing of problems and the opportunity to talk has proved of considerable value. It is felt that as the Club is run on very informal lines and is not authoritarian in any way this has a beneficial effect. Both the Mental Welfare Officers attend each week and if a member wishes to talk to either of them privately this can be arranged in a spare room. The members have a sense of belonging, a pride in the Club and a desire to help each other. Transport is arranged for a limited number of the members, the need being mainly due to age or physical handicap or anxiety. The age range is 16 to 75 years and most patients belong to the middle age group. Dr. Dransfield, Consultant Psychiatrist at High Royds Hospital, Menston, considers that these clubs are of great value. They enable a much more satisfactory and close contact to be maintained with discharged patients and others in need of treatment for mental illness. They are of assistance with socialization, particularly where there are asocial trends and also immature dependent personality traits. Where the return to mental health is incomplete they can continue to give a degree of support which is invaluable and when the return to mental health is complete the social club can often provide a stepping stone to the resumption of a normal role in society. Dr. O'Brien, Consultant Psychiatrist at Scalebor Park Hospital says that assistance is only necessary for a fairly small percentage of cases, say 10 per cent. The help of the mental welfare officer he finds useful in dealing with the organisation of patients' social activities, encouraging them to persist at work and in the occasional crisis caused by demanding patients. He suggests that the work of the mental welfare officers has kept three or four psychotic patients out of hospital by encouragement and support.

Morley Psychiatric Social Club

The club opened in January, 1962, and meets once a week in the Central Clinic at Morley. The attendance is not very high but some members have attended regularly and one or two who have been able to return to work cannot now find time to attend. The members take part in table tennis, dominoes and card games

and the use of a record player. Tea and biscuits are served by way of refreshments.

Rock House Psychiatric Club, Swinton

This club was opened in August, 1961, with an initial membership of 6. Attendances have increased steadily and the average membership has grown to 20. Club meetings are held on alternate Thursday evenings and suggestions and ideas are invited from members for sessional activities which have included demonstrations, hairdressing, cake icing, floral decorations and film shows. The membership of the club is predominantly female with an age range from 22 to 60 years. The last session each evening is generally given over to panel games, dominoes, darts, whist, etc.

A yearly outing is arranged to a pantomime in a nearby town and visits to other clubs are encouraged. Guest visitors from Middlewood Hospital Sunshine Club have been entertained and the members of the Swinton Club paid a return visit to the Hospital Club. This proved to be a very popular arrangement. There are many helpers at the club, amongst those who are particularly helpful being the Women's Guild, the Cine Club, members of the Inner Wheel and of the League of Friends.

Two female members of the psychiatric club are now active members of the Operatic Society and another attends evening classes in cake decoration. Only one female patient has required readmission to hospital. The members have developed a sense of belonging to a group and a new sense of responsibility and confidence in mixing with people has been promoted. Finally, so far as can be reasonably ascertained there is no stigma attached to membership of the Club or the feeling that it exists for one particular type of person.

Castleford and Normanton Psychiatric Social Clubs

The Castleford Club was opened on the 13th September, 1961, and has an average weekly attendance of 29 members. The Normanton Club was opened on the 7th May, 1962, and the average weekly attendance is 16 members. Regular recreational activities are bingo, lexicon, dominoes, table tennis and dancing and the occasional activities have included film shows of members' holiday slides, games introduced by members, competitions with the tape recorder—spot the tune, recognition of voices and noises, members recordings, etc., beetle drives, darts and "sing-songs". Infrequently talks and debates have been arranged but there has been little demand or support for this type of activity.

A very interesting little experiment has been carried out, the question "What do you get out of the Club?" has been put to 12 members and the 12 answers which are quoted below give a very enlightening picture of what is being achieved and also of the difficulties still to be overcome.

"I just can't mix properly outside. I know it sounds silly, especially as I work in a shop and am meeting people all day, but I only feel really comfortable at the Club—people understand my feelings there."

"I can see other members going through various stages of illness just as it happened to me. So I understand them and feel I can help them in the same way that I have been helped."

"You can talk about things—things you are stuck with—you can get them out of your head. You can't do that outside—people don't understand. In exchange I try to help other members to relax and put them at their ease."

“ I come for the company because I think of you all as true friends. I can talk things over and know I will get sympathy and help.”

“ There is more understanding of my troubles here than with my own brothers and sisters. I feel at home and look forward to it all week. You don't get it so sociable anywhere else—everybody mucks in.”

“ It's brought me out of myself. Before I came here I didn't like to meet people but now I seem to have more confidence. I even dare go to a dance now—before I would have been scared daft.”

“ The friendship. You can get friends outside but it is not the same. The Club companionship is of a special type—you can confide and know you will be understood and neither laughed at nor let down.”

“ I'm inclined to keep things bottled up and if I don't get them off my chest I'm a b—— to live with. I can shoot off my mouth at the Club. You can't do that outside—they don't understand—with them it's a case of ' I'm all right Jack '.”

“ I came to begin with to please the M.W.O.—I didn't see much point in it really. Now I come to please myself because I have found real companionship here. And it works two ways—others at the Club help me and I try to help those who are worse off than I am.”

“ I don't trust people outside. I've been let down badly in the past so I have become a lone wolf. Even when I go to a pub I drink by myself. I just daren't make close contacts outside in case I am let down again. At the Club it is different—I can talk about things here and feel to be safe and among real friends who won't let me down.”

“ Before I came to the Club I was afraid to go out of the house but now I dare go shopping by myself. But I still can't seem to make friends outside—it is different at the Club because everyone is so sociable. Unless folk have been mentally ill themselves they just don't understand.”

“ With me it is a form of escapism—I hate to be left alone with my thoughts. At the Club the companionship helps me to forget my troubles and for a few hours I feel secure.”

On analysis these answers indicate that some have benefited by an increase in self-confidence; others are themselves encouraged by their ability to help fellow members. The real common denominators, however, appear to be “ companionship ” and “ talking things over ”, perhaps best expressed by the member who said “ The Club companionship is of a special type—you can confide and know you will be understood and neither laughed at nor let down.”

A somewhat disturbing feature is the frequent reference to lack of understanding “ outside ”, this word being used presumably to indicate the social environment. If this is in fact true, then mental health propaganda aimed at the general public has been singularly unsuccessful.

A further point of interest is that in replying to the question, not a single member referred to the attraction of the recreational activities. One must conclude, therefore, that although these activities are essential as a medium through which to draw the members together, they are subordinate to the main aims, which are supportive and therapeutic.

The 4 U. Club, Halifax

This club is held in Halifax, is now in its second year and is well established. It is an example of co-operation between Hospital Committees and local authorities and approximately 80 West Riding patients are members at the club which was formed at the instigation of a Consultant Psychiatrist to the Halifax Area Hospitals Management Committee. Halifax County Borough and West Riding patients who have been in-patients either at the Halifax General Hospital Unit or Storthes Hall Hospital attend and a certain amount of group therapy is practised on a limited scale. Members are encouraged to express themselves on common social problems and on talks by the Consultant Psychiatrist. Social activities take up part of each evening and the group is large enough to allow individual members to withdraw from specific activities if they so wish. A few of the members, none of whom is mentally subnormal, are regarded as attending in lieu of clinic sessions. To our friends of the Halifax Authority we are indebted for the open welcome they have offered to the West Riding members.

Huddersfield Psychiatric Social Club

The Huddersfield Authority have opened a club and have agreed that West Riding members shall attend from the Colne Valley Area. 10 such members have attended since November, 1962, and most of them appear already to have derived benefit—in fact one has also joined a Working Men's Club but one attended only once and took no willing part in any activity. Tea and biscuits are provided. A Christmas party was held out of the proceeds of the sale of refreshments. The activities have included discussions, card games, billiards and darts and also a cookery demonstration enjoyed by both male and female members.

Psychiatric Out-patient Clinics:

The following is a schedule of Psychiatric Out-patient Clinics at which West Riding patients were attending at the end of 1962.

Skipton General Hospital
Salt's Hospital, Shipley
St. James's Hospital, Leeds
Farfield House, Farsley, Leeds
Harrogate General Hospital
Ripon and District Hospital
War Memorial Hospital, Selby
St. Bartholomew Hospital, Goole
The Nerve Clinic, Beancroft Road, Castleford
Pontefract General Infirmary
Staincliffe General Hospital, Dewsbury
Brighouse, C.W.C., Atlas Road
Halifax General Hospital
Huddersfield Royal Infirmary
Sheffield City General Hospital
Southmoor Hospital, Hemsworth
Barnsley Beckett Hospital
Doncaster Royal Infirmary
Moorgate General Hospital, Rotherham
Doncaster Gate Hospital, Rotherham

Some of these clinics are open for more than one session per week and West Riding officers attend at each session. Their work is much appreciated by the Psychiatrists in attendance and they obtain invaluable experience and knowledge by working closely with the Psychiatrists.

A psychiatric unit for in-patient treatment was opened at the Halifax General Hospital during the year and a fair number of patients from the County areas around received treatment there instead of being admitted to the Storthes Hall Hospital. The Mental Welfare Officers undertake the social casework in respect of the patients and an excellent working arrangement and close liaison has sprung up between them and the Hospital Almoner.

Some of the Mental Welfare Officers accompany the Psychiatrists on domiciliary visits and are thus able to make frequent contact with the general practitioners and further strengthen the link between the various agencies of a good community service. Approaches initiated by the Divisional Medical Officer have been made to the Leeds Regional Hospital Board to try to arrange the establishment of an out-patient clinic at County premises in Tadcaster. Unfortunately this is not possible at present but the idea is being kept in mind. The out-patient facilities are leading to an improvement in the after-care provided and an overall increase in the amount of field work and domiciliary visits.

Case Conferences:

Case conferences are now held at all the large psychiatric hospitals and the Psychiatric Social Worker-Tutor attends if possible as does the Senior Administrative Medical Officer for Mental Health and the Mental Welfare Officers employed in the catchment areas of the various hospitals. These conferences do not follow the same pattern in all hospitals. They serve a variety of useful purposes. They bring together all hospital and local authority workers who are concerned with the case under discussion. This ensures a better understanding and knowledge of the patient's and his family's total problem and fosters a more co-ordinated approach towards its solution. Action can often be initiated without delay. Through these regular meetings hospital and local authority workers keep each other informed about the progress of the patients under their care. Most of the case conferences also play an important part in the In-Service Training Scheme by giving Mental Welfare Officers the opportunity of presenting cases and of hearing the opinions of a number of medical and non-medical workers who discuss fully the various aspects of patients' condition and care.

Hostels:

Progress has been made with the three hostels planned and the demand for hostel accommodation during the year has increased. Psychiatric patients have again been supported at the hostels already provided by the County Boroughs in the Riding and at those of the S.O.S. Society and it is clear that our planned hostel with 20 places would have worked to capacity. One problem is undoubtedly that of subnormal adults who have lived a sheltered existence in children's homes and those who have been working from hospitals. When the time comes for them to return to the community they so often find themselves in difficulties, particularly during their leisure hours and at holiday times. Again many subnormals who have lived with parents and led a useful life have found themselves unwanted and homeless on the death of their parents. Local Health Authorities have a duty to provide care for these patients and the hope is that the hostel will bridge the gap prior to their return to the community or being found new homes. The provision of hostel accommodation might well lead to an expansion of the guardianship scheme in the locality of the hostels. At one or two of the larger hospitals some efforts have been made to provide an employment officer, but it is felt that this job is far better left to the Mental Welfare

Officer particularly if the return to community life is by way of the hostel. Many times now one is asked whether this patient is a responsibility of the hospital or local authority, particularly when one is seeking a hospital bed for the mentally subnormal, but I am still of the opinion that my original thoughts on this subject, outlined in my 1959 Report, are still valid.

Statistics:

The number of patients referred to the Local Health Authority during the year, together with the number of patients under local health authority care at 31.12.1962 are shown on the tables at the end of the Section. The Consultants in charge of the hospitals for the subnormal again responded nobly to the many demands made for short stay care, particularly during the months of July and August, and 169 patients were provided with short stay care during the year. The number of subnormal patients urgently in need of hospital care is again 37, but these are mostly new referrals. It is heartening to know that patients on the urgent waiting list no longer have to wait years before there is any hope of a place being provided.

Two subnormal adults, one male and one female, were admitted to Guardianship, the man from hospital and the woman by order of Court. The total number under guardianship at the end of the year was 8, two males and 6 females, all of them adults. 81 patients were admitted to hospitals for the mentally subnormal as permanent cases, 37 being under the age of 16 years; 65 were admitted informally, 11 by order of the Courts and 5 on the application of Mental Welfare Officers or nearest relatives. Mental Welfare Officers were concerned in the admission of 1,920 patients to psychiatric hospitals and of these 996 were informal admissions. There were 1,728 referrals for after-care.

There are 88 epileptic and 59 spastic patients attending the Training Centres, and 12 who suffer from both epilepsy and spasticity.

General observations on the progress of the Mental Health Service:

The progress made in all aspects of the training centres has been mentioned, but from the 15th October—1st November, 1962, Miss Gavin and Mrs. Curzon of the Ministry of Health visited all the Centres to survey the facilities for the training of the mentally subnormal. They are old friends with a knowledge of the County, having visited many times, the last occasion being 1957. We have reason to be very satisfied with their observations on the progress made. We are committed to comprehensive training and quite apart from the economics of the situation believe that the comprehensive centre has much to offer. It is important to realise that we have developed rapidly and the situation is rendered even more difficult by changes in emphasis from time to time during the course of development. Separation into Adult and Junior Training Centres now would be difficult. Programmes of training for children are separate and distinct however from that for adults.

In the order of priorities for this new service the appointment of a sufficient number of Social Workers to help or advise all mentally disordered persons whether or not they had been in hospital, has been given first place over the development of the training facilities and the provision of residential accommodation. We believe now that the Mental Welfare Officers of the Authority under the guidance of Mrs. Farrow and the Senior Mental Welfare Officers, are developing into skilled case workers.

From the beginning the emphasis was on team spirit, the Mental Welfare Officers working in a Health Division and at the same time having an overall interest in the area of the Psychiatric Hospital concerned, and wider in the County as a whole. An instance being that the psychiatric social clubs so far formed have extended beyond the boundaries of divisional areas, and the Mental Welfare Officers attending have come from wide areas to help. The undoubted ability of the officers and service provided is amply expressed in reports received from the Regional Hospital Boards' consultants. In a County embracing seven Mental Health areas and served by two large Regional Hospital Boards we do not expect uniformity, but we are receiving the utmost co-operation and are able to see the various trends. Thus from one area we are able to assess the value of the hostel, from others the leaning towards the day centre, the value of treatment being provided in a general hospital, the daily attendance at the occupational therapy unit of the hospital, the attendance at the psychiatric social clubs of patients about to be discharged from hospital, the out-patient clinic provided by the local authority and the psychiatric social club conducted by a psychiatrist. So many and different courses, so many and new treatments which are all put to the officers at their in-service training programmes, in many cases, too, by the Consultants themselves. It is pleasing to record the interest being shown by the public, for now we have support and help in our ventures from people who have no direct connection with the work. Some of the developments and difficulties experienced by the Divisional Medical Officers are worth recording.

Dr. Hunter has three group training classes, 17 trainees attend the Keighley Training Centre, one goes to Accrington and one to Nelson.

Dr. Burn has a successful out-patient follow up clinic at Pudsey which is conducted by Dr. Milne, Consultant Psychiatrist, and is attended by one of the County Mental Welfare Officers. It is held weekly, and general practitioners in the area often take the opportunity to discuss cases with the psychiatrist. Dr. Smithson has trainees attending the Airedale, East Leeds, York and Harrogate Centres, and some patients attend the Psychiatric Social Club at Castleford. In the rural areas it is most difficult, and clearly here the services of a home teacher has much to commend it. Dr. S. K. Appleton had hopes of opening a day social club in the premises formerly used as a group training class at Snaith but negotiations regarding staffing with the Leeds Regional Hospital Board have been protracted. These difficulties appear now to have been resolved.

35 trainees from Dr. Fraser's division attend the Airedale Training Centre but by the end of the year a waiting list had developed. Dr. Withnell, in addition to the Junior Training Centre at Ossett, had trainees travelling to Wakefield, Leeds and Airedale. The psychiatric club at Morley has operated throughout the year and one or two members have been able to return to work. Dr. Withnell observes that the salary of a Mental Welfare Officer is less than the yearly cost of keeping one single person in hospital and, apart from the economics, there is a measure of human happiness involved. The potentialities of the Mental Health Service for the welfare of the community are truly immense. Dr. Caithness comments upon the steady progress of the service, on the co-operation that exists between the mental welfare officers and the Hospital Services both through the local out-patient clinics and the periodic visits of the officers to Storthes Hall for the case conferences. The general practitioners have an excellent liaison with the officers and particularly interesting is the integration with all the other branches of the Public Health Service which is possible when the officers are housed under one roof. Dr. Taylor's officers have heavy commitments at psychiatric clubs but the possibilities of a club for the subnormal in the area have not been overlooked. The new Training Centre to be opened next year

will meet a pressing demand as the trainees have all a good deal of travelling to do at the moment. Dr. F. Appleton refers to the 4 U's club at Halifax, 50 patients from his area being members. The local authority's out-patient clinic at Brighouse had 61 new referrals and attendances during the year totalled 448. The psychiatric unit at the Halifax General Hospital opened during the year and in the second half of the year, 21 patients from the division received treatment there instead of at Storthes Hall Hospital. Time consuming though it may be, the Mental Welfare Officers accompany the Psychiatrists on the domiciliary visits and the observations of the consultant that the aim of the visits is to reduce and not augment the number of admissions, and that things can be decided right away on the spot, have a good deal to commend them. Dr. Gordon, too, has some 30 members of the 4U club from his division. Twenty trainees attend the Stansfield View Hospital daily and five children attend the Brighouse Training Centre. The opening of the Psychiatric Unit at Halifax, here again, has involved the Mental Welfare Officers in additional duties.

Dr. Ward's patients have access to the Huddersfield Psychiatric Club; pending the new centre at Kirkburton, the group training class has continued to function; the work in the Division has been a little handicapped by frequent changes of staff. Dr. Main Russell's staff at the Training Centre have held social evenings once a month at which old time and modern dancing form part of the entertainment. These evenings are well attended by adult patients and by their parents. A sports day was held at the centre in July and various leisure and pleasure outings were organised. On the 15th January, 1962, a letter was sent to all local authorities in the Middlewood Hospital Mental Health Area inviting the attendance of medical officers and officers concerned with the question of the resettlement of discharged patients. These meetings continued at regular intervals until the 6th December, 1962, when there was a final meeting. Arising out of the final meeting a Working Party was appointed, and one of the first duties imposed upon it was to make a comprehensive survey of all patients discharged from the hospital during the period October, 1961 to March, 1962. Dr. Barnes is still in some difficulty regarding the welfare of the mentally ill in his division. The out-patient clinics serving the area are staffed by Consultants of the Sheffield Regional Hospital Board, the division being in that area, and yet patients requiring hospital treatment have to go to Storthes Hall. It is hoped that this position will be dealt with next year. At Dr. Cusiter's psychiatric club, the Women's Guild, Cine Club, Members of the Inner Wheel and ladies from the League of Friends have been helpful, at the Training Centre there is a flourishing parent/teacher association and bi-monthly social evenings are greatly enjoyed. At a Mental Health Exhibition held at Goldthorpe, a display of work done at the training centre was presented for public inspection. Dr. Watt comments that a sheltered workshop in the area would be a valuable asset in giving better contact between the local authority and the hospital services and would transform the scheme for after-care.

Number of patients referred to Local Health Authority
during year ended 31st December, 1962.

Referred by	Mentally Ill				Psychopathic				Subnormal				Severely Subnormal				Totals				Grand Total
	Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
General practitioners	3	2	466	714	—	—	2	2	—	—	—	—	—	—	—	—	3	2	468	716	1189
Hospitals, on discharge from in-patient treatment	2	2	508	683	—	—	4	—	—	—	1	2	—	—	—	—	2	2	513	685	1202
Hospitals, after or during out-patient or day treatment...	3	1	270	437	—	—	—	—	1	—	—	—	—	—	—	—	4	1	270	437	712
Local education authorities	—	—	—	—	—	—	—	—	97	75	6	8	—	—	—	—	144	116	6	8	274
Police and courts	1	6	69	53	—	—	1	—	—	1	3	—	—	—	—	—	1	7	73	53	134
Other sources	1	9	159	250	—	—	—	—	9	3	15	12	—	—	—	—	19	19	174	265	477
Total	10	20	1472	2137	—	—	7	2	107	79	25	22	—	—	—	3	173	147	1504	2164	3988

Number of Patients under L.H.A. care at 31.12.62	Mentally Ill				Psychopathic				Subnormal				Severely Subnormal				Totals				Grand Total
	Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
Total number	6	4	775	1198	2	2	7	1	288	256	808	836	191	168	219	237	487	430	1809	2272	4998
Attending day training centre	—	—	4	—	—	—	—	—	199	181	148	158	114	83	76	81	313	264	228	239	1044
Awaiting entry thereto	—	—	1	—	—	1	—	—	18	8	33	34	12	16	5	8	30	25	39	42	136
Resident in a residential training centre... ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Awaiting residence therein	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Receiving home training	—	—	3	1	—	—	—	—	—	1	3	12	—	1	6	11	—	2	12	24	38
Awaiting home training	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Resident in L.A. home/hostel	—	—	5	7	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Awaiting residence in L.A. home/hostel... ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Resident at L.A. expense in other residential homes/hostels	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Resident at L.A. expense by boarding out in private household	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Receiving home visits and not included above	6	4	762	1190	2	1	7	1	71	66	624	632	62	68	131	134	141	139	1524	1957	3761

PART V

ENVIRONMENTAL HYGIENE

Food and Drugs

Sanitary Circumstances

Atmospheric Pollution

ENVIRONMENTAL HYGIENE

By the end of the year the reorganisation of the Public Health Inspectors' Section of the Department had not been effected. Plans had, however, been drawn up ready for submission early in the new year.

Reorganisation became necessary not only because of the heavy burden imposed upon the section in carrying out statutory duties under the Milk (Special Designation) Regulations, 1960, but also due to a broadening in scope of work which had been envisaged for some considerable time.

In the field of atmospheric pollution, the new scheme for measurement by the use of volumetric equipment has meant a considerable amount of time being spent advising County District Officers on the siting and operation of this equipment and interpretation of results.

The ready co-operation of County District Officers, on the varied environmental health problems, has continued and co-operation with other County Departments is being developed. The main examples of the latter have been with the County Planning Officer in the investigation of rural water and sewage schemes, atmospheric pollution and redevelopment areas, and with the County Education Officer regarding school swimming pools and the schools meals service.

With the above examples of expansion, current duties and other avenues still to be explored once staff becomes available, it is hoped that the section will make a really worthwhile contribution to the work of the Department.

Food and Drugs Act, 1955:

THE MILK (SPECIAL DESIGNATION) REGULATIONS, 1960:

The County Council, as a Food and Drugs Authority, have now had the duty of administering the above Regulations for two years except in the areas of the autonomous Food and Drugs Authorities, Batley M.B., Castleford M.B., Harrogate M.B. and Keighley M.B.

Although plans are now in an advanced state of preparation for the extensive reorganisation of the Public Health Inspectors' section it has been impossible to carry out any regular system of inspection and sampling of dealers so far.

The principal action taken has been the visiting of applicants for new licences or applicants taking over businesses. Many visits were made for this purpose alone, as will be seen by the increase of 196 licence holders in the tables given later, but it was considered to be time well spent to ensure that newcomers to the milk trade were made aware of requirements and were operating from satisfactory premises. Unfortunately, many newcomers to the trade are unaware of the necessity for licencing and registration and are sometimes taken aback when the requirements of the law are made known to them.

There is also no doubt that in the past many dealers have been allowed to operate from unsatisfactory premises including roadside dropping points and this is a legacy which will be rectified once staff are available. The obvious risks of fouling by animals and exposure to weather makes such measures very necessary.

The following table gives details of dealers licences at the end of the year (excluding licenced pasteurised and sterilised milk establishments which are set out later):—

Number of Licence Holders	Bottling of T.T. Milk (Raw)	Dealing in Pre-packed T.T. Milk (Raw)	Dealing in T.T. Milk (Pasteurised)	Dealing in Pasteurised Milk	Dealing in Sterilised Milk
3,125	20	384	785	967	2,480

Given below are details of licenced establishments for the pasteurising and sterilising of milk.

PASTEURISED MILK:

Airedale Co-operative Society Ltd., The Dairy, Thomas Place, Shipley.
 Count, G. W., The Dairy, St. Mary's Gate, Tickhill, Doncaster.
 Crawshaw, J., Blake Lea Dairy, 103, Arksey Lane, Bentley, near Doncaster.
 Doncaster Co-operative Society Ltd., Dairy Department, York Road, Doncaster.
 Doxey, C., Armthorpe, near Doncaster.
 Goole Co-operative Society Ltd., Centenary Road, Goole.
 Harrison, R. H., Manor Farm, Conisbrough, near Doncaster.
 Mawer's Dairy, Glentworth House, Skellow, near Doncaster.
 Oates, J. E. & E., Thorne Dairies, 3, North Eastern Road, Thorne, near Doncaster.
 Pontefract Industrial Co-operative Society Ltd., Dairy Department, Horsefair, Pontefract.
 Rotherham Co-operative Society Ltd., The Dairy, Progress Drive, Bramley, near Rotherham.
 Salmon, P., Ashbrooke, Littlethorpe, Ripon.
 Stocksbridge Co-operative Society Ltd., Shay House Lane, Stocksbridge, near Sheffield.
 West Marton Dairies Ltd., West Marton, Skipton.
 Whittaker's Wholesale Dairies Ltd., 77, Tenter Balk Lane, Adwick le Street, near Doncaster.
 Wholesale Dairies (Rotherham and District) Ltd., Claypit Lane, Rawmarsh, nr. Rotherham.

STERILISED MILK:

Wholesale Dairies (Rotherham and District) Ltd., Claypit Lane, Rawmarsh, nr. Rotherham.

During the year the following pasteurising plants ceased operations:—

Express Dairies (London) Ltd., Barnoldswick, via Colne, Lancs.
 Maxfield, A. E., Ivanhoe Dairy, 37, Church Street, Conisbrough, near Doncaster.

and the following establishment commenced:—

Count, G. W., The Dairy, St. Mary's Gate, Tickhill, Doncaster.

These premises have continued to have priority for inspections and sampling of milk processed.

When one considers the enormous amount of milk processed at these premises and sold not only in the administrative area of the County but in neighbouring Counties and County Boroughs the necessity for close supervision is apparent.

The general standard of operation has been good but it was continually necessary to remind dairy staffs of hygiene requirements such as the provision of clean towels and the wearing of clean clothing and head coverings.

It is unfortunate that, in an industry from which health problems could quickly arise, the calibre of staff available is not always of the desired standard.

A number of alterations and improvements were carried out at processing plants. At one large dairy extensive structural alterations were effected which gave far superior accommodation for pasteurising equipment and the bottling of cream. Another badly designed and overcrowded small family dairy was completely reconstructed and is now highly satisfactory. Discussions took place regarding the closure of a large dairy which was beginning to get into a poor state of repair and decoration and where working conditions were very cramped. The decision was ultimately made to retain the premises for a further period and the necessary repairs and redecoration were carried out. A further small family dairy was found, due to lack of capital and insufficient labour, to be deteriorating rapidly and strong pressure had to be brought upon the owner to bring the premises up to a satisfactory standard.

Particular attention has also been given to those dealers buying raw tuberculin tested milk in bulk and bottling it at registered premises. Visits were made to premises and samples of milk obtained but only on a far inferior scale to that intended once additional staff become available.

Details of samples obtained by the County Public Health Inspectors from dealers licenced by the County Council, with results of examinations, are given below:—

Tuberculin Tested (Raw)		Tuberculin Tested (Pasteurised)				Pasteurised				Sterilised	
Methylene Blue Test		Phosphatase Test		Methylene Blue Test		Phosphatase Test		Methylene Blue Test		Satisfactory	Unsatisfactory
Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.		
57	3	142	—	141	1	253	1	252	2	20	—

Thanks are due to Dr. Little, Director of the Public Health Laboratory, Wakefield, for dealing with the above samples. The kind co-operation of Dr. Smith, Director of the Public Health Laboratory, Bradford, who keeps us informed of samples submitted to his laboratory and helps to avoid unnecessary duplication is also appreciated.

SUPPLY OF MILK TO SCHOOLS:

All suppliers of school milk have to be approved by this Department and every endeavour is made to ensure that a pasteurised supply is provided.

Sixteen suppliers of raw tuberculin tested milk have, by necessity, been accepted but it is gratifying to report that all samples taken were satisfactory in the methylene blue test, also in the biological examination for tuberculosis and brucella abortus.

SAMPLING OF MILK AT HOSPITAL FARMS:

Only two such farms producing tuberculin tested milk remain in the administrative area of the County. These farms are at Stanley Royd Hospital, Wakefield, and Stansfield View Hospital, Todmorden.

Seven samples were obtained from each farm and two of these from each were submitted to a biological examination in addition to the methylene blue test.

All samples obtained proved satisfactory in the methylene blue test and were found negative for tubercle and brucella abortus.

Copies of all reports were furnished to the Ministry of Health, Leeds Regional Hospital Board, the appropriate Hospital Management Committee and the Medical Officers of Health concerned.

BIOLOGICAL SAMPLING:

By Section 31, Food and Drugs Act, 1955, a specific duty is laid upon County and County Borough Councils to ensure that milk from a cow suffering from tuberculosis or other disease listed in the Act is not sold for human consumption or used in the manufacture of products for sale.

Without doubt the most pressing problem has become the necessity to prevent the sale of raw milk infected by brucella abortus. This organism is the cause of abortion in cattle and is responsible for undulant fever in man.

Undulant fever is not notifiable in England and Wales or in Scotland but reports from the Public Health Laboratory Service for England and Wales for the three years 1959-61 show 88, 84 and 101 cases respectively. The true incidence of cases with illness is commonly believed to be far higher and one estimate has been put at over 1,000 cases per annum.

Indications that brucellosis is not yet a diminishing problem are seen by the fact that according to Ministry of Health figures the number of notices served by Medical Officers of Health under Section 20 of the Milk and Dairies (General) Regulations, 1959, had more than doubled between 1959 and 1961 when 70 and 149 notices respectively were served.

The majority of sampling for biological examination is carried out by County District Officers at the present time and recently an increase in the amount of sampling undertaken has been noticeable due to keener interest on their part.

The sampling procedure is as follows:—

Herd samples are taken and submitted to a Public Health Laboratory for examination. Where these are found to be positive by cream culture test or by guinea pig inoculation compulsory pasteurisation orders are served.

As soon as possible after this individual cow samples are taken in order to determine the actual infected cow or cows. Where samples from individual cows give a negative ring test the order is lifted from them and their milk may again be sold without heat treatment.

This system of quickly identifying infected cows helps the producer to regain his uninfected raw milk for sale without undue delay.

The majority of producers are co-operative and send the milk of infected animals for pasteurisation. There are others, however, who send the infected animals to an open market where they may be bought for slaughter or inclusion in another milking herd. It is most unsatisfactory that no powers exist to stop this practice and it would appear that an eradication scheme on the lines of the one adopted for tuberculosis is urgently needed.

I give below details of samples submitted for examination:—

Tuberculosis		Brucella Abortus			
Number Examined	Number Positive	Number Examined Ring Test	Number Positive	Number Examined Culture or Guinea Pig	Number Positive
675	27	2,536	779	1,603	279

REPORT OF ANALYST:

All County Inspectors of Weights and Measures are also appointed sampling officers for the purpose of the Food and Drugs Act and the work of sampling is under the control of the Chief Inspector, Mr. J. W. Hopkinson. Details of the work carried out under the Act are referred to in the Annual Report to the County Council of Mr. Mallinder, the County Analyst, who has kindly consented to their inclusion in this report.

“ During the year, 3,421 samples were submitted by your Inspectors under the Food and Drugs Act, 1955, as set out below:—

	Total Samples	Adulterated or Below Standard	Percentage Adulterated or Below Standard
Milk	1,688	41	2·4
Milk ‘ Appeal to Cow ’ ...	22	—	—
Milk, Channel Islands ...	236	8	3·4
Milk, Hot	9	7	77·7
Milk Bottle	1	1	100·0
Other Foods and Drugs ...	1,465	93	6·3
All samples	3,421	150	4·4

Notes on adulterated or irregular samples

Milk. The proportion of adulterated samples is low. Out of 1,688 samples of ordinary and sterilised milk, 23 were deficient in fat, the worst being 69·6 per cent. deficient. 18 were adulterated with water, the most flagrant example containing 41·5 per cent. added water.

Channel Islands Milk is the subject of special regulations and should contain at least 4 per cent. of fat; it is not unusual to find 6 per cent. fat in these samples. Out of 236 samples, 8 were below standard, the lowest fat being 3·52 per cent.

Hot Milk. 7 samples out of 9 were found to be below standard. Three samples were deficient in fat, one being 43 per cent. below standard. Added water was found in 4 other samples, the worst adulterated contained 17 per cent. added water.

Sausages. In the absence of a legal standard for sausages, Public Analysts continue to require 50 per cent. of meat in Beef Sausages and 65 per cent. in Pork Sausages. The majority of samples comply.

Beef Sausages. 117 samples were examined. All were satisfactory as regards meat content. 10 samples contravened the Preservatives in Food Regulations by containing sulphur dioxide without proper declaration being made by label or notice. The average meat content was 64·7 per cent.

Pork Sausages. 76 samples were analysed; only 4 contained less than 65 per cent. of meat; the lowest content being 55 per cent. The average meat content was 69·5 per cent.

Potted Meat and Potted Beef. The 31 samples of Potted Meat had an average meat content of 75·9 per cent. 8 of these were adversely reported since they contained below 70 per cent. meat. 4 of these samples also contained cereal filler. 9 samples of Potted Beef all contained over 70 per cent. of meat; the average meat content was 79·0 per cent. Two samples were irregular in that they contained cereal filling.

Preserves.

Cranberry Preserve. 2 samples were below standard in Soluble Solids, and should have been sold as Cranberry Sauce.

Home Made Lemon Cheese. 1 sample was deficient in Soluble Solids. Samples with this defect would soon deteriorate and become mouldy.

Damson Jam. 1 sample was below standard in Soluble Solids.

Dripping. 1 sample, with a peculiar taste, had deteriorated and developed an excess of fatty acids.

Flour. 3 samples were below standard in the added nutrients, iron and creta præparata.

Fish Cakes must contain at least 35 per cent. of fish, whereas 2 contained only 19 per cent. and 24 per cent. respectively.

Tea. 2 samples were mouldy and unfit for use.

Sweets.

Butterscotch should contain at least 4 per cent. of butter fat, but 2 samples contained only 1·3 and 0·6 per cent. respectively.

Rum and Butter Toffees were adversely reported in that they contained only 2 per cent. of butter fat instead of the expected 4 per cent.

Tinned Milk Puddings. ‘Creamed’ rice and sago puddings should be made with full cream milk. 4 samples were found to have been compounded with skimmed or partially skimmed milk.

Vitamin Preparations are liable to deteriorate and lose their protective value with age. 26 samples of Halibut Liver Oil Capsules were examined, 11 had irregular labels (see below) and 7 were substandard in Vitamins.

Rose Hip Syrup. This is an important source of Vitamin C. 4 samples were analysed, 3 were unsatisfactory on account of labelling irregularities, 1 also being deficient in Vitamin C.

Labelling. Hundreds of labels were examined for compliance with the Labelling of Food Order, and compared with the analysis of the sample.

Sometimes an imported article complies with the standards and regulations of the country of origin but not with those of Britain. We received a ‘Cranberry Preserve’ of Canadian manufacture, which was actually Cranberry Sauce. Similarly ‘Prune and Plum Butter’ from the Continent contained no butter at all, and should have been labelled ‘puree’ or ‘spread’.

A Milk Chocolate Smoker Set was wrongly described by the label, since some of the items in the box were moulded in ordinary plain chocolate.

Attention was drawn to the labels on containers of several Halibut Liver Oil Capsules; these failed to declare their vitamin potency and did not include the date of production. These details are most important because vitamin preparations usually deteriorate with long storage.

Foreign Bodies. The majority of discoveries of foreign bodies in foods are made by members of the public and brought to the Inspectors.

Here are some examples:—

A bilberry pie contained a beetle; this was about the shape and size of a bilberry and had doubtless been collected and processed with the imported bilberries. There was a moth grub in a cherry cake; a fly in a chicken pie; a bee in a tin of apricots; a wasp in Dundee cake, and a small fly in a loaf of bread. One loaf of bread contained green stains of copper compound, another contained suspicious looking black specks which proved to be simply

particles of burnt bread. The purchaser of a packet of sugar was horrified to find therein an insect about 1½ in. in length. This was identified as a horntail, a member of the sawfly family. There was a hole in the packet such as would be bored by the larvæ of these insects. It appears that a larva cut its way into the packet, pupated amongst the sugar and so became a fully developed horntail.

A bottle of milk contained splinters of glass; these were shown to be fragments from another bottle of the same type.

Amongst the meat in a beef sausage was a piece of steel wire.

Prohibited Colouring Matters. All appropriate samples were tested for artificial colouring. Only 1 sample was irregular; this was a polony in which the meat filling was stained by colour from the skin, the colour itself being amongst the dyes not permitted for use in food."

The County Council's scheme operated in conjunction with District Council Public Health Inspectors continued throughout the year. In accordance with regulations made under the scheme, the County Council pays the fees of the County Analyst for all samples of milk taken by the inspectors, conducts all legal proceedings and defrays consequential legal expenses. The number of samples submitted for analysis was 196 of which two were found to be below standard; both were deficient in fat. Both samples were only slightly sub-standard and a caution was issued to the vendor by the Clerk of the County Council in one case and no action taken in the other.

Sanitary Circumstances:

FLUORIDATION OF WATER SUPPLIES:

In December the Ministry of Health issued Circular 28/62, indicating that he was ready to approve, under Section 28 of the National Health Service Act, 1946, the making of arrangements with water undertakers for the addition of fluoride to water supplies which are deficient in it naturally.

The Health Committee considered this Circular and a report setting out the history of scientific investigations carried out both in America and the United Kingdom into the effect on dental caries of the fluoridation of water supplies. They resolved that approval in principle be given to the making of arrangements with water undertakers under Section 28 of the National Health Service Act, 1946, for the addition of fluoride to water supplies which are deficient in it naturally, and that the necessary approach be made to water undertakers with a view to securing this objective.

Following this decision the Clerk of the County Council wrote to the 30 water undertakers and the 80 County District Councils who are not water undertakers requesting that the resolution be considered by the Authority.

At the time of writing, although no scheme has reached fruition, 11 of the water undertakers have indicated that they are in favour of fluoridating their water supplies and 2 have referred the matter back for further consideration. In the remaining cases no decision has yet been reached.

With regard to the non water undertakers, 54 authorities have supported the decision, 3 are not in favour, and 4 have recommended that no action be taken at the present time. Replies from the remaining 19 authorities are still outstanding.

The subject has been thoroughly discussed with divisional medical officers who have also been supplied with a wealth of information and technical data to support this far reaching public health measure which has aptly been described as a 'simple, safe, natural and proven way of laying foundations for healthy teeth'.

PLUMBO-SOLVENT WATER SUPPLIES:

The periodical examination of water from those public supplies in the West Riding which are known, or suspected, to possess plumbo-solvent properties has been carried out.

Two samples of water were collected from each supply (a) after standing all night and (b) after standing for thirty minutes in a lead service pipe, and the samples were examined for the presence of lead. One hundred and twenty-four samples from 61 supplies were examined and in each case the result of the examination was notified to the Medical Officer of Health and other appropriate officer of the County District concerned.

The standard adopted for many years by this Department has been that a water supply which is plumbo-solvent to the extent of taking up 0.1 grain or more of lead per gallon is dangerous and that the plumbo-solvency of such a water should be neutralised.

Only one of the samples contained lead in excess of 0.1 grain per gallon and appropriate action was taken. Subsequently a repeat sample was satisfactory.

One other sample contained lead but not in excess of 0.1 grain per gallon.

It is now generally agreed that 0.1 parts per million should be the limit for lead in drinking water, but where lead piping is installed, the concentration of lead in the water after prolonged contact with the pipes may be higher; in no instance, however, should the concentration of lead exceed 0.3 parts per million after sixteen hours contact with the pipes.

This is obviously a stricter standard than the current West Riding one but will be adopted from next year. Reports then will be given to show lead concentration in parts per million.

PRIVATE SUPPLIES OF WATER TO SPECIAL AND OTHER SCHOOLS:

Supervision of private supplies has again been undertaken. Details of the samples obtained are appended:—

School	Source of Supply	Bacteriological Examination		
		Number of samples obtained	Sat.	Unsat.
Grantley Hall Adult College, near Ripon	Land springs	6	6	—
Hatfield Levels School, Thorne, near Doncaster	Bore, 202 feet deep	5	4	1
Ingleborough Hall Special School, Clapham, Settle	Lake water	4	4	—
Netherside Hall Special School, Grassington, near Skipton	Land springs	6	4	2

With the exception of Hatfield Levels School all premises are provided with chlorinating equipment. Action was taken regarding unsatisfactory reports and repeat samples proved satisfactory.

The samples from Ingleborough Hall Special School were again obtained by the Chief Public Health Inspector, Settle Rural District Council, to whom thanks are due for his co-operation.

RURAL WATER SUPPLIES AND SEWERAGE ACTS, 1944-61:

Details of applications for grant made during the year:

County District or Other Body	Description of Scheme	Date of Application	Estimated Amount of Scheme
			£
Claro Water Board	Heyshaw & District Water Scheme	4th April	11,200
do.	Mickley Water Scheme	19th September	—
Craven Water Board	Kildwick Water Scheme	15th January	8,427
do.	Salterforth Water Scheme	18th January	9,250
Doncaster R.D.	Green Lane, Brodsworth— Sewerage Scheme	10th April	14,196
Goole R.D.	East and West Cowick, Snaith, Gowdall and Pollington Sewerage and Sewage Disposal Scheme	27th November	215,185
do.	Airmyn Sewerage and Sewage Disposal Scheme	22nd January	32,985
do.	Rawcliffe Road, Airmyn Sewerage Scheme	11th December	—
Nidderdale R.D.	Boroughbridge Sewage Disposal Works— Enlargement (2) Coneythorpe Arkendale (3) Little and Great Ouse- burn	26th November	42,900
do.	South Stainley Sewerage Scheme	26th November	49,266
Osgoldcross R.D.	Hillam & Monk Fryston Sewerage and Sewage Disposal Scheme	27th April	11,500
do.	Eggborough and Whitley Sewerage and Sewage Disposal Scheme	9th May	83,000
Penistone R.D.	Crowedge Water Scheme—Revised	15th October	147,000
do.	Silkstone Sewerage and Sewage Disposal Scheme	5th February	720
Ripon & Pateley Bridge R.D.	Grewelthorpe Sewerage Scheme— Revised	25th September	37,400
do.	Galphay Sewerage Scheme	6th February	12,184
do.	Laverton Sewerage Scheme	6th February	19,142
do.	Dacre, Darley, Wilsill and Summerbridge Sewerage Scheme	15th February	11,026
do.	Burnt Yates and Scarah Sewerage Scheme —Revised	17th May	105,630
do.	Enlargement of sewage works at Shaw Mills	24th May	40,900
Saddleworth U.D.	Slackcote and West View Area Water Supply Scheme	29th October	2,500
Selby R.D.	Camblesfoith & Carlton Sewerage and Sewage Disposal Scheme	13th April	7,125
do.	Brayton Sewerage Scheme—Revised	8th May	84,241
Sowerby Bridge U.D.	Hubberton, Sowerby Water Supply Ex- tension—Amended Scheme	29th November	80,703
Tadcaster R.D.	Healaugh Sewerage and Sewage Disposal Scheme	2nd February	9,510
		11th April	16,322

County District or Other Body	Description of Scheme	Date of Application	Estimated Amount of Scheme
			£
Tadcaster R.D.	Acaster Malbis Sewerage and Sewage Disposal Scheme	20th July	13,741
Thorne R.D.	Hatfield Woodhouse Sewerage Scheme—Revised	16th February	29,700
Wakefield & Dist. Water Board	Chevet Hall Water Supply Scheme	19th July	1,200
do.	West Bretton Water Supply Scheme	30th October	25,000
Wakefield R.D.	Notton Sewerage Scheme	29th March	57,150
Wetherby R.D.	Moor End, Boston Spa—Sewer extension	11th April	1,160
Wharfedale R.D.	Askwith Sewerage Scheme	5th January	3,293
do.	Fewston—Hardisty Hill Sewerage Scheme	11th December	5,735
Doncaster C.B.	Newton, Sprotborough Water Supply Scheme	21st March	780

It is pleasing to note that once again the number of applications has increased. This work is undoubtedly allowing many sub-standard houses to be improved and provided with the modern facilities which so many of us take for granted. The town dweller tends to forget that the privy midden at the bottom of the garden is still harsh reality to many in country districts.

All schemes submitted for grant are now examined by the County Public Health Inspectors' section with emphasis on sanitary arrangements for the area. Comments are passed to the County Planning Officer, with whom extremely cordial co-operation has been maintained, to enable joint observations to be forwarded to the County Council's Consulting Engineer.

It is hoped that more time will be available for the investigation of these schemes once the reorganisation of the section has taken place and additional staff appointed.

Pharmacy and Poisons Act, 1933:

Part II of this Act deals with poisons which may be sold from the premises of "listed sellers", i.e., persons registered with the County Council for the purpose. A shopkeeper may sell any Part II poison (i.e., any substance included in Part II of the Poisons List and not exempted by the Poisons Rules), provided that his name and the address of his premises are entered in a list kept by the County Council, in accordance with Section 21 of the Act.

Any sales must be effected on the premises specified in the County Council's list. The term "premises" is not defined in the Act, although the Home Office has advised that sales may not be effected from vans or from travelling shops, or from barrows or stalls. It is, however, permissible for poisons previously ordered to be delivered from the shop or van. No poisons may be sold from an automatic vending machine. Part II poisons must be labelled with the name of the poison, and with the name of the retailer and address of the premises from which they are sold.

A Poisons Register is required to be kept on the premises for certain poisons sold, with the name and address of the purchaser, date, etc., recorded.

It is the duty of the County Council (as a "local authority" under the Act) to carry out from time to time inspections at "listed sellers" premises and the County Public Health Inspectors carry out the duties involved, generally in the course of their other various duties in the County Districts.

Two hundred and twenty-four inspections were made and it was apparent that, in some cases, compliance with the terms of the Act were not being observed by the sellers, mainly in connection with the correct labelling requirements.

Atmospheric Pollution:

As referred to in last year's report a reappraisal of the County's scheme for the measurement of atmospheric pollution, in conjunction with the Department of Scientific and Industrial Research, was undertaken during 1961 and the scheme received the approval of the County Council in January, 1962.

Implementation of the scheme proceeded and at the year end 31 District Councils were participating involving 28 combined daily smoke filter and sulphur dioxide instruments and 9 daily smoke filters only. The results of the instruments operating appear in the table below:—

Situation of Daily Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	High-est Value	Low-est Value	Average Daily Concentration SO ₂ *	High-est Value	Low-est Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Keighley—First Floor of Public Health Department in built-up area in centre of town	171	2,164	16			
Bingley—Health Department, Town Hall, Bingley, 1/5th mile outside town centre, surrounding district park land	104 for 7 months	615	8	124 for 7 months	1,395	0
Otley—First Floor of Council Offices, in town centre, mainly manufacturing	47 for 11 months	206	5			
Pudsey 2 (Stanningley)—"Southville", Sunfield House, 20 ft. above ground on East side, surrounding district mainly industrial	149 for 5 months	> 2,044	3	181 for 5 months	2,827	6
Pudsey 3 (Farsley)—Farfield House, Farfield Avenue, 20ft. above ground on north side, surrounding district residential	174 for 5 months	> 2,132	29	219 for 5 months	3,337	40

*For period of full year unless stated otherwise.

Situation of Daily Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	High- est Value	Low- est Value	Average Daily Concentration SO ₂ *	High- est Value	Low- est Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Pudsey 4 (Calverley)—M. & C. W. Clinic, Chapel Street, 20ft. above ground on west side, surrounding district parkland and residential	162 for 5 months	>2,148	18	215 for 5 months	3,362	19
Ripon—Health Department High Skellgate, in centre of country town.	75 for 10 months	307	10			
Wetherby—Council Offices, residential, surrounded by open country from $\frac{1}{2}$ to $\frac{3}{4}$ mile distant	78	665	4			
Goole—Health Department, Municipal Offices, Stanhope Street, surrounding area commercial, residential and shipping	147 for 10 months	864	16	116 for 7 months	573	17
Castleford—First Floor of Divisional Health Office, in residential area of industrial town	285	1,932	44			
Horbury—Ground floor lobby of Town Hall, facing east 12ft above ground, surrounding district residential and manufacturing	216	2,416	21	208 for 9 months	3,156	17
Morley—Public Health Inspector's Department, Commercial Street, surrounding district residential, commercial and manufacturing	227	2,616	28	441 for 1 month	2,419	30
Batley—Public Health Department, Market Place, in centre of mixed residential, commercial and manufacturing district	233	2,396	28			
Spennborough—Divisional Health Office, Elm Bank, manufacturing area	153	2,028	16	180 for 10 months	1,897	35
Elland—Council Offices, 20ft above ground in manufacturing area.	210	2,000	0	201 for 8 months	2,045	0

*For period of full year unless stated otherwise.

†Instrument previously at Divisional Health Office and was moved to present site on 4th June, 1962.

‡Instrument previously at Sewage Works and was removed to present site on 3rd April, 1962.

Situation of Daily Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	High- est Value	Low- est Value	Average Daily Concentration SO ₂ *	High- est Value	Low- est Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Elland (Holywell Green)— In garage of private house, in main residential area of manufacturing district	129 for 6 months	852	12	126 for 6 months	784	0
Hebden Royd (Mytholm- royd)—Redacre Sewage Works, residential and manufacturing area, open country to north	112	595	13	104	918	7
Hebden Royd (Hebden Bri- dge)—On second floor lan- ding of Council Offices, in centre of mixed residential, commercial and manufac- turing district	145 for 6 months	948	19	156 for 6 months	936	13
Todmorden—In first floor room on south side of Med- ical Centre, surrounding district mixed residential, commercial, manufacturing and open country	184	1,516	16	179	1,711	22
Colne Valley—Town Hall, Cross Street, Slaithwaite, in mixed residential and textile manufacturing dis- trict	178	2,052	40	148 for 6 months	1,662	19
Denby Dale—Public Health Inspector's Office, surround- ing district mixed residen- tial, manufacturing and open country	121 for 7 months	480	22	118 for 7 months	567	31
Holmfirth—On second floor landing of Council Offices, Town Hall, surrounding district open country, resi- dential, commercial and manufacturing	131 for 7 months	562	28	157 for 7 months	1,871	23
Kirkburton—Council Depot, Highroyd, Lepton, 11 ft. above ground, surrounding district residential. Hud- dersfield C.B. 4 miles to the east	208 for 4 months	736	46	145 for 4 months	904	0
Meltham—Public Health Inspector's Office, Town Hall, surrounding district residential, manufacturing and open country	132 for 7 months	660	32	122 for 7 months	1,104	13

*For period of full year unless stated otherwise.

Situation of Daily Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	High- est Value	Low- est Value	Average Daily Concentration SO ₂ *	High- est Value	Low- est Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Saddleworth—Sewage Works, Shaw Hall Bank, Green- field, surrounding district residential, manufacturing and commercial	128	896	11	67 for 9 months	609	0
Wortley (Grenoside)—Health Dept., Council Offices, sur- rounding area industrial and manufacturing	94	585	2	142 for 5 months	904	32
Wortley (Oughtibridge)— County School, Church Street, surrounding district industrial and manufactur- ing	73 for 5 months	590	9	112 for 5 months	1,000	0
Hemsworth—Divisional Health Office, Adiscombe House, in residential area	221 for 11 months	1,608	9	114 for 8 months	592	0
Darton—Council Offices, in semi-residential colliery dis- trict. Coke by-product plant 1 mile to the S.E.	184	1,476	8	144 for 7 months	1,167	0
Wombwell—The Gables, semi-residential colliery dis- trict	272	1,644	40			
Conisbrough—Denaby Clinic, in room facing north. Sur- rounding district residential —high density	215 for 10 months	1,784	32	163 for 10 months	1,054	44
Conisbrough—The Priory, in staff dining room facing west. Surrounding district residential—low density	169 for 10 months	1,632	23	142 for 10 months	1,086	21
Rawmarsh—Public Health Inspector's Office, in centre of residential and industrial area	287	1,516	0			
Bentley with Arksey—Health Department, Chapel Street, semi-residential colliery dis- trict	200	1,640	32	136 for 8 months	936	31
Doncaster (Barnby Dun)— Barnby Dun School, in resi- dential area 5 miles north- east of Doncaster C.B.	120 for 5 months	684	0	99 for 5 months	496	0

*For period of full year unless stated otherwise.

Situation of Daily Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	High- est Value	Low- est Value	Average Daily Concentration SO ₂ *	High- est Value	Low- est Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Thorne—Council Offices, in semi-residential colliery district	115	684	29			
Kiveton Park—The Chelms- ford Mining and Technical Institute, Dinnington, sur- rounding district open park land with built up area to the south and west	264 for 3 months	888	28	214 for 3 months	729	28

*For period of full year unless stated otherwise.

Consideration of participation in the County scheme is proceeding in a number of County Districts and it is anticipated that there will be further expansion of the scheme in 1963.

The selection of sites for the instruments was undertaken in conjunction with the staff of the D.S.I.R. and County District Officers and additionally numerous discussions were held with County Districts Officers before and after the coming into operation of the instruments to advise on procedure and interpretation of results.

I should like to take this opportunity of thanking the staff of the D.S.I.R. and the District Councils concerned for their continued helpful co-operation.

PART VI

MISCELLANEOUS

**The Ten-Year Plan for the Development
of the Health Services**

Welfare of the Epileptic and Spastic

**Certification and Treatment of Blind
and Partially Sighted Persons**

National Assistance Act, 1948

Residential Accommodation

**Disabled and Old Persons'
Homes**

**Persons in need of Care and
Attention**

Registration of Nursing Homes

Notification of Births

**Nurseries and Child-minders Regulation
Act, 1948**

**Medical Arrangements for County Children's
Homes and Residential Nurseries**

Medical Examination for Superannuation

West Riding Distress Fund

THE TEN-YEAR PLAN FOR THE DEVELOPMENT OF THE HEALTH SERVICES

The County Council were asked by the Minister of Health in Circular 2/62 to review their Health and Welfare Services and to draw up a plan for developing them over the ten years 1962 to 1972.

For a fully-developed community health service, it was necessary not only to consider the relationship with the hospitals but also the common field of activities with the general practitioners and voluntary bodies. Only by all these agencies outside the hospital providing together a comprehensive community service can there be hope of attaining anything reasonably near the Minister of Health's intention of reducing the hospital burden. All these factors were, therefore, borne in mind in developing the plan; there was also consultation with the general practitioners through the West Riding Medical Committee and the West Riding Executive Council and with the Leeds and Sheffield Regional Hospital Boards.

Two methods of approach were used. Firstly, an examination of the existing services leading to an estimation of what expansion, if any, was required to meet the new situation, and—secondly—a search was made for gaps between the various services which, if satisfactorily filled, would take the plan nearer to the desired end.

It was necessary also to relate the plan to the declared policy of the Minister for the development of the hospital services (Command Paper 1604—A Hospital Plan for England and Wales). With this as a guide, it was found that four common factors had to be taken into account, viz:—

- (a) *Maternity Beds.* The increased provision of hospital beds with the declared intention of providing for seventy per cent. of confinements to take place in hospital. This, together with the increased emphasis on antenatal care and mothercraft training will undoubtedly affect our domiciliary midwifery services.
- (b) *Mental Health Beds.* The proposed run-down of mental health beds will call for an increased community service. It is in accordance with the policy of the Mental Health Act and called for a review of our proposals under that Act.
- (c) *Geriatric Beds.* The increase in geriatric beds in the county as a whole will be more than offset by the increased aged population, and there will be need for an increasing and augmented community service.
- (d) *The District General Hospital.* This new concept of centralising the hospital service will inevitably have its effect on the complementary domiciliary services, but it is as yet too early to measure what these effects will be.

The pattern of Divisional Administration is well suited to cope with the envisaged development. Changes there will be as the opportunity arises to effect the amalgamation of the smaller divisions into larger units; further changes are to be expected when the final proposals of the Local Government Boundary Commission are known, subject to the necessary approvals. It has become increasingly obvious that, as these changes take place, the aim must be towards co-terminous divisions for the personal services, i.e., health, welfare, children's and education services.

It is within this administrative pattern and in co-ordination with the developments of the hospital service that our own ten-year plan has been prepared, the main features of which are —

Health Centres. The new health centre at Cleckheaton will be built in the early years of the development period. It remains the sole project of its type although no suitable opportunity will be neglected for further development in this sphere.

Clinics. Fifteen specific projects for the building of new clinics are included in the first three years of the development period. This programme will be extended as may become necessary by the obsolescence of existing buildings or by schemes of redevelopment affecting existing premises.

The 'Mini-Clinic'. Concurrently with this traditional development, it is intended to introduce a new type of clinic for areas of small population. These buildings will be planned for general use by all aspects of the health and welfare services. In sharp contrast to the urban 'health centre', it is proposed that the county health services, welfare services, general practitioners and the associated voluntary organisations shall share common premises and that these small multi-purpose buildings will evolve as rural health centres. Where necessary, it is also suggested that living accommodation for nursing staff should be included in the building. Problems of design and costs have yet to be finalised, but a successful outcome will present a major break through in the ever-present county problem of taking the static services to areas of low-density population.

Midwifery. It will continue to be necessary to maintain a strong domiciliary midwifery service. Although the hospital plan provides for a higher overall ratio of hospital confinements, an increasing number of hospital cases are being discharged home to the care of the midwife, whose own work is being affected by the increased attention to antenatal care and mothercraft teaching. At the present time, however, there is no indication of any need for an increased domiciliary midwifery staff.

Health Visiting. The development of the community health services will make greater demands on the health visiting service. This factor has to be reconciled with the knowledge that intensive efforts to recruit more health visitors have merely resulted in the replacement of staff who have left the service, and it has not yet been possible to recruit up to the present authorised establishment.

Dilution has been a reluctant expedient of the past and the present indications are that, if the qualified health visitor is to play her full part in the development of the services, further dilution will be necessary. Our own proposals, therefore, provide for the recruitment of a staff of 50 auxiliaries in excess of the present authorised establishment. These auxiliaries, together with the assistant health visitors who now dilute the service, will be used to relieve the qualified health visitor of those duties which do not require her special skills.

The health visitor is called upon from time to time to undertake social work of a nature which does not require her nursing skills and, particularly where intensive case work is required, such demands can cause a serious interruption of her other duties. To meet this situation, it is proposed to introduce social workers into the local health authority services. Initially, a staff of 25 has been envisaged but this number may be varied in the light of further experience.

Home Nursing. It is not possible to forecast with any degree of precision the changes in the pattern of home nursing which are likely to arise from the hospital plan. It appears probable that, with the demise of the local hospital, a number of patients who have been referred to hospital will in the future be nursed in their own homes rather than be admitted to the more-distant district hospital. Changing concepts of the role of the hospital may combine with economic consideration to prompt the earlier discharge of patients from hospital as, indeed, is now evidenced in the maternity hospitals, and such a development may make increased demands on the home nursing service. Against these possibilities can be offset the advantages likely to arise from the advances in medical knowledge and medical care, particularly with regard to the aged.

Changes in the pattern of domiciliary treatment have already eased the pressure on the home nursing services, and the present establishment is probably adequate to meet the changes which can be foreseen. At this juncture, therefore, no increase in the home nursing staff is envisaged, although adjustments may be made in the light of future events.

Health Education and Propaganda. The Authority's health education service is rapidly expanding, with the Deputy County Nursing Officer acting also as Health Education Officer. Such has been the recent rate of progress that it has become necessary to consider the appointment of a whole-time health education officer.

With the co-ordination of health education throughout the Authority's area, the use of sound film projectors and film-strip projectors is being augmented by modern propaganda techniques and the introduction of specialised apparatus. The preparation of this apparatus and of the demonstration material which is in demand requires the services of a skilled technician, and such an appointment is included in the development plan.

Domestic Helps. In the fourteen years of the National Health Service, the Authority's establishment of home helps has increased from 300 to its present 1,050. These are the whole-time equivalent of part-time staff which has consistently numbered more than twice the establishment figure.

The future expansion of the home help service is dependent almost wholly upon the needs of the aged and consequently will be affected by the increasing number of aged people in the community. We have therefore suggested a first increase of 100 with further expansion to be determined in the light of experience.

Mental Health Service. The Authority's proposals for the development of a community mental health service are based on:—

- (a) The provision of a sufficient number of mental welfare officers to provide a home visiting service and to help or advise all mentally-disordered persons.
- (b) The development of adequate training facilities.
- (c) The provision of residential accommodation.

The County Council have approved an establishment of 7 senior mental welfare officers and 46 mental welfare officers. With the development of the hospital plan and the increasing emphasis on community care, it is now becoming apparent that a further increase in staff will be necessary if the individual case loads are to be kept within manageable proportions. It is therefore, proposed to increase the establishment by 12 to a total of 65 mental

welfare officers, including the senior appointments.

Four psychiatric social clubs have been opened in the Authority's area and development in this sphere is envisaged with the aim of ensuring that there is at least one such club in each division.

The Authority now has 15 training centres—12 comprehensive and 3 junior—providing 861 places. Buildings now in course of erection or planned for completion within the next three years will increase this number to 20, with 1,462 places, and will ensure accessible training-centre facilities in all parts of the Authority's area. It is already becoming evident that the need for training facilities is likely to exceed that provided for in the original proposals. Additional accommodation will be provided as may be necessary, estimated at 100 more places within the first five years and a further 250 to complete the development programme.

The Authority is planning the erection of a residential hostel for 30 sub-normal adults and of two residential hostels, each for 8 subnormal children. The extent of need for such accommodation cannot be assessed with any degree of accuracy, but it appears probable that this initial programme will need to be duplicated during the second half of the development period and suitable provision is being made.

For post-psychotic patients, the Authority has proposed the erection of a residential hostel, providing some 30 places and sited within easy access of centres of employment. Further development will be determined on the basis of experience from this one hostel, but accumulating evidence from other parts of the country suggests that this is no sphere for rapid development and, therefore, at this juncture it is not proposed to proceed beyond this pilot venture.

A logical development in the mental health service is the establishment of a limited provision of psychiatric day centres to give social encouragement and support for patients living in the community. These will be provided as may be necessary, estimated on the basis of one for each mental health area, a total of seven in all, and the majority is likely to be opened within the first five years of the development period.

Staff. The development of the health services will make increasing demands on staff of all categories. Staff hitherto not referred to include the medical and clerical staff, both groups being vitally affected by the proposals.

The medical staff is engaged jointly in the local health authority and school health services and was last reviewed in 1955. An increase of establishment, at least in proportion to the increased population, is necessary, representing a further 8 whole-time officers or their equivalent in part-time officers employed on a sessional basis over the ten-year development period.

The clerical staff was last reviewed in 1961, but will need to be augmented in order to deal with the developments now envisaged, and provision is made for a modest increase within the first five years of the development period.

THE WELFARE OF THE EPILEPTIC AND SPASTIC

The following are the particulars of known epileptics and spastics :

<i>Adults</i>	<i>Number</i>	
	<i>Epileptics</i>	<i>Spastics</i>
Provided with accommodation under Part III of the National Assistance Act, 1948:		
(a) in homes for epileptics 	84	
(b) in homes for spastics and other handicapped persons 		25
(c) in County establishments and establishments where County Council has "right of user" 	50	
Registered under the County Council's scheme of Welfare Services for Handicapped Persons (General Classes) 	124	133

Children

Number ascertained as handicapped:

(a) Approximate number attending ordinary schools	Not known	89
(b) Attending special schools 	25	93
(c) Receiving home tuition 	—	2
(d) Attending Training Centres for the Mentally Subnormal 	88	59

The register of handicapped persons, including epileptics and spastics, under the approved scheme has been kept up to date and the information recorded includes the medical classification and assessment of their suitability for employment. Again much thought has been given during the year to furthering the County Council's approved scheme under Sections 29 and 30 of the National Assistance Act, 1948. A few centres are being operated through the County Council and the agency of voluntary organisations in the County Boroughs and these generally serve handicapped persons in the contiguous West Riding areas. Social and handicraft centres have been established at Harrogate, Morley, Pontefract, Wombwell, Ripon, South Kirkby, Rossington, Thurcroft and Skipton. In addition local branches of the National Spastics Society are now operating in several districts of the West Riding, at York, Leeds, Bradford, Halifax, Dewsbury, Huddersfield, Barnsley, Sheffield, Pontefract, Castleford and Goole.

There were nine full-time handicraft instructresses working in the County during the year. From this agency over 903 handicapped persons were actively engaged in home handicraft work and a number were epileptics and spastics.

There are numerous avenues for the disposal by sale of the articles produced; some are disposed of by private arrangements of the persons concerned, and assistance is afforded to others to obtain orders and sales. Voluntary organisations and many persons of goodwill have been helpful in providing means of sale and their assistance is gratefully appreciated.

Again advice to handicapped persons on their various problems and assistance and liaison with other statutory bodies is effected through nine Divisional Welfare Officers.

Financial assistance was given to handicapped persons (including a number of spastics) in respect of internal and/or external adaptations to their homes or in respect of the provision of additional facilities designed to secure their greater comfort or convenience.

The County Council made grants to organisations providing voluntary services for handicapped persons and grants were made to the Spastic and Epileptic Societies.

CERTIFICATION AND TREATMENT OF BLIND AND PARTIALLY SIGHTED PERSONS

The following table gives particulars of new registrations during 1962 of blind and partially sighted persons (other than handicapped school children).

	Disability (B.—Blind, P.S.—Partially Sighted)									
	Cataract		Glaucoma		Retro-lental Fibroplasia		Others		Total	
	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.
(i) Number of cases registered during the year in respect of which Section F recommends:										
(a) No treatment	94*	64†	8	3	—	—	113	51	215	118
(b) Treatment (medical, surgical, optical or hospital supervision)	132=	83‡	27	12	—	—	60	56	219	151
(ii) Number of cases at (i) (b) above which received treatment ...	73	52	22	11	—	—	41	49	136	112

* Includes 9 cases of cataract with glaucoma.

† Includes 3 " " " " "

‡ Includes 12 " " " " "

= Includes 29 " " " " "

RESIDENTIAL ACCOMMODATION

(National Assistance Act, 1948)

Under the scheme for residential accommodation the County Medical Officer is responsible for the general medical oversight of the following:—

<i>Establishment</i>	<i>Superintendent/Matron</i>	<i>Telephone Number</i>	<i>No. of Residents</i>	
			<i>Men</i>	<i>Women</i>
The Shroggs, Skipton Road, Steeton	Miss E. M. Wolstenholme	Steeton 3213	—	20
Farfield Hall, Bolton Road, Addingham	Mrs. H. Otter	Bolton Abbey 241	11	19
Neville House, Neville Crescent, Gargrave	Mr. and Mrs. M. Carling	Gargrave 349	13	21
Sharow View, Allhallowgate, Ripon	Mr. and Mrs. E. Brook	Ripon 238	43	30
The Beeches, Leeds Road, Tadcaster	Mr. and Mrs. H. G. Jenner	Tadcaster 2113	71	40
*11, Stockwell Road, Knaresborough	Miss W. M. Brown (Matron) Mr. T. K. Hayward (Secretary)	Knaresborough 2283	54	33
Wharfedale Lawn, Westgate, Wetherby	Miss D. E. Pearson	Wetherby 2446	—	23
The Grove, 80, High Street, Starbeck	Miss A. Smithson	Harrogate 83980	—	19
Fircroft, Wighill Lane, Tadcaster	Miss L. E. Wilkes	Tadcaster 3204	11	16
Hillworth Lodge, Oakworth Road, Keighley	Mr. and Mrs. D. Moor	Keighley 4014	73	129
Thornton View, Thornton View Road, Pasture Lane, Clayton, Bradford	Mr. and Mrs. F. Innis	Queensbury 2007/8	100	100
Woodville, Spring Gardens Lane, Keighley	Mrs. G. H. French	Keighley 2428	9	11
Crow Trees, Leeds Road, Rawdon	Mrs. H. M. Lewis	Rawdon 2908	—	20
Burley Hall, Burley in Wharfedale, near Ilkley	Miss E. S. Atkinson	Burley in Wharfedale 2334	7	20
Park House, 41, Lister Lane, Bolton, Bradford	Mr. and Mrs. G. H. Fletcher	Bradford 39913	22	—

<i>Establishment</i>	<i>Superintendent/Matron</i>	<i>Telephone Number</i>	<i>No. of Residents</i>	
			<i>Men</i>	<i>Women</i>
Glenholme, Green Lane, West Vale, Greetland	Mr. and Mrs. H. H. Senior	Elland 2985	20	20
Stoneswood, Oldham Road, Delph	Miss M. C. Murphy	Delph 300	8	12
Longlands, Leeds Road, Lightcliffe, near Halifax ...	Miss A. Dickinson	Halifax 68254	8	12
Scaitcliffe Hall, Burnley Road, Todmorden	Miss L. Holt	Todmorden 114	10	14
Stanley View, Park Lodge Lane, Wakefield	Mr. and Mrs. F. W. Radley	Wakefield 2188	137	93
Beech Towers, Halifax Road, Staincliffe, near Dewsbury	Mr. and Mrs. N. W. Jones	Dewsbury 4051/2	156	148
Walton House, Shay Lane, Walton, near Wakefield ...	Mrs. D. Wright	Wakefield 5242	—	20
Turnsteads, Whitcliffe Road, Cleckheaton	Mrs. J. E. L. Thwaites	Cleckheaton 2972	—	23
Brook Lodge, Brook Street, Selby	Mr. and Mrs. J. E. Whitworth	Selby 15	63	70
Northgate Lodge, Skinner Lane, Pontefract	Mr. and Mrs. C. Borrill	Pontefract 3351/2	100	64
Mill Garth House, Mill Hill Lane, Pontefract	Mr. and Mrs. J. T. Fenton	Pontefract 3593	11	33
Wadworth Hall, Wadworth, near Doncaster	Miss M. Bakewell	Doncaster 53272	9	18
Don View, 22, Thellusson Avenue, Scawsby, near Doncaster	Mr. and Mrs. C. Stoney	Doncaster 2257	15	23
Rolleston House, High Street, Maltby	Mr. and Mrs. G. T. Nutt	Maltby 2118	16	25
Oaklands, Oakdale, Worsbrough Bridge	Mr. and Mrs. F. E. Rodgers	Barnsley 5529	12	29
Netherfields, Sheffield and Halifax Road, Penistone ...	Mr. and Mrs. T. W. H. Lambert	Penistone 2144	37	29
Wombwell Grange, Park Street, Wombwell	Mrs. K. M. Smith	Wombwell 2186	—	17
Mortomley House, High Green	Mr. & Mrs. G. A. Smith	High Green 323	18	27

* County Council have "right of user."

REGISTRATION AND INSPECTION OF DISABLED AND OLD PERSONS' HOMES

(*National Assistance Act, 1948*)

The following premises, which are inspected in conjunction with the officers of the Welfare Department, are registered as Disabled and Old Persons' Homes.

<i>Establishment</i>	<i>Number of Residents</i>	<i>Type of Home *(Part I, II or III)</i>
Congregation of Sisters of Charity of our Lady of Good and Perpetual Succour, St. Anne's Convent, Burghwallis, Doncaster ...	23	I
Mrs. Bessie Fox, Moor Lane House, Moor Lane, Gomersal...	10	I
Harrogate Old People's Home, 66-68, Cold Bath Road, Harrogate ...	36	I
Skelldale Housing Society Ltd., Borrage House, Borrage Lane, Ripon	12	I
Ernest Ayliffe Home for the Deaf and Dumb, Fulford Grange, Rawdon	32	II
North Regional Association for the Blind, "Oaklands," Huddersfield Road, Holmfirth ...	30	II
Keighley & District Institute for the Blind, 13-15, Scott Street, Keighley	27	II
Mrs. M. L. Harris, The Woodlands, Farrer Lane, Oulton ...	21	I
Methodist Homes for the Aged, "Glen Rosa," Grove Road, Ilkley...	32	I
Methodist Homes for the Aged, Berwick Grange, 5, Otley Rd., Harrogate	34	I
Highfield Home for the Blind, Soothill Lane, Batley ...	14	II
Catholic Women's League, Clitherow House, 49, Valley Dr., Harrogate	16	I
Miss L. W. Miller, "Greylands," Forest Moor, Knaresborough ...	7	I
Miss Anna F. Schramm, "Moor Top," 43, Harlow Moor Drive, Harrogate	8	I
Mrs. I. Brearley, S.R.N., Haversham Court, Ben Rhydding Road, Ilkley	28	III
Mrs. D. Wood, Gratton Home for Aged Ladies, 11, East View Terrace, Otley ...	14	I
Mrs. A. C. Shepley, Batley Hall, Upper Batley	10	I
Harrogate Guild of Help (Avondale Trust Ltd.), "The Avondale," Cold Bath Road, Harrogate	20	I
Mrs. K. D. Clarke, "Newlands," 58, Harlow Moor Drive, Harrogate	7	I
Yorkshire Association for the Care of Cripples, St. George's House, Otley Road, Harrogate ...	70	II
Mr. William Kneen, The Gables, Norland, Sowerby Bridge ...	11	I
Mrs. M. Fell, Oakfield, Thwaites Brow, Keighley ...	5	I
Mrs. B. M. Veall, Lansdown, 46, Kent Road, Harrogate ...	12	I
Mr. John McCormick, "Burnlee House," Park Head, Holmfirth ...	17	I
Mrs. Minnie Satariano, "Downside," 15, Otley Road, Harrogate ...	15	I
Mrs. Queenie Mona Marsh, Portland House, 14, Leeds Rd., Harrogate	6	I
Mrs. P. C. Rayfield, The Grange, Woodlesford, near Leeds ...	5	I
Mrs. Alice McConney, Elm Bank, 242, Park Lane, Keighley ...	8	I
Mrs. June Valentine Minogue, Straygarth, 42, York Place, Harrogate	17	I
Mr. Douglas Kneen, Thorpe House, Triangle, near Halifax ...	15	I
Mrs. Doreen May Thompson, Brooklands, Harper Lane, Yeadon ...	6	I
W. H. and R. E. Higgins, Housley Manor, Housley Hall Lane, Chapeltown ...	14	I
Pentecostal Eventide Housing Association, Brooklands, Bakewell,		
Pentecostal Eventide Home, Bradford Road, Wrenthorpe ...	30	I
Mrs. Hester Walker, Granville House, Exley Road, Keighley ...	9	III
Mrs. A. G. Turner and Miss G. Carradice, Ghyll Court, The Wells Walk, Ilkley ...	12	I
Mrs. K. M. Pay, 60, Franklin Road, Harrogate	5	I
Mr. F. Vasey (Kildare Lodge Ltd.), Kildare Lodge, 23, Park Drive, Harrogate	9	I
Mrs. Mary Morrison, Pembury, 44, St. Mark's Avenue, Harrogate ..	4	I
Miss Beatrice Anne Hartley, Hartwell Home, Raincliffe, Thorpe Hesley	22	I
Mrs. Freda Mary Hodge, The Redlands, 21, Grove Road, Harrogate	6	I
Keighley and District Institution for the Blind, Home for the Blind, Westfield, Bromley Road, Bingley ...	16	II
Mrs. Kathleen Gregg, Huntingdon House, 15, Farnley Road, Menston	3	I
Mr. C. & Mrs. N. A. M. Gould, Hartrigg Guest House, Buckden, via Skipton ...	10	I
Mrs. M. Roche, St. Alban's Rest Home, 8, South Park Road, Harrogate	5	I
Mr. J. Richardson, Pentecostal Eventide Home, Aismunderby Close, Quarry Moor Lane, Ripon ...	18	I
Mrs. Dorothy Pearson and Mrs. S. H. Mottram, Thornlea Villas, Holme House Road, Cornholme, Todmorden	4	I
Mrs. L. Lawrence, Fearby House, 77, High Street, Starbeck, Harrogate	5	I

<i>Establishment</i>	<i>Number of Residents</i>	<i>Type of Home *(Part I, II or III)</i>
Mr. Geoffrey Noble and Mrs. Brenda Ainsworth, Bankfield Guest House, Hollins Lane, Sowerby Bridge	8	I
Mrs. S. M. Frankland, Brintcliffe Old Persons' Home, 1, St. Mary's Avenue, Harrogate	5	I
Mrs. Emma Band, Scott Bank, Hollins Lane, Sowerby Bridge ...	3	I
Mrs. M. L. Rennison, Lyndon Rest Home, 30, Ripon Road, Harrogate	8	I
<i>Incorporated by Royal Charter</i>		
Lister House, Sharow, near Ripon	70 approx.	III (and Hospital cases)

* Part I—Homes for Old Persons

Part II—Homes for Disabled Persons.

Part III—Homes for Old and Disabled Persons.

In 1956, all County District Councils were informed that the County Council were prepared to consider the making of contributions (now made under Section 56 of the Local Government Act, 1958) towards the expenses incurred by them in the development of services for aged persons accommodated on Council estates subject to the submission of schemes containing full details of the proposals.

During the period July, 1957, to January, 1963, 206 schemes have been approved by the County Council, affecting 53 District Councils.

I am indebted to Mr. F. B. Armstrong, County Welfare Officer, for supplying most of the foregoing information in this part of the Report.

REMOVAL TO SUITABLE PREMISES OF PERSONS IN NEED OF CARE AND ATTENTION

Medical Officers of Health are empowered, under Section 47 of the National Assistance Act, 1948, to initiate proceedings for persons suffering from grave chronic disease or being aged, infirm and living in insanitary conditions to be compulsorily removed to hospital or Part III accommodation. In urgent cases action may be taken under the National Assistance (Amendment) Act, 1951.

Reports of Medical Officers of Health indicate their reluctance to enforce these powers; the proceedings, resented by every official concerned are, however, unavoidable in certain instances. Unfortunately it was necessary to remove five men and one woman to hospital; also three men and two women to accommodation provided under Part III of the National Assistance Act, 1948.

REGISTRATION OF NURSING HOMES

(Public Health Act, 1936 — Sections 187-195,
Mental Health Act, 1959 — Section 15 (1))

There were 1 new registration and 7 amended registrations, making a total of 34 homes registered, providing 35 beds for mental cases, 25 beds for maternity cases and 402 beds for other cases. Thirty-three visits of inspection were carried out. The following schedule gives brief details of the nursing homes in the area on the 31st December.

Name and Address of Nursing Home	No. of Beds Registered			Other Information
	Mental	Maternity	Other	
Brooklands Nursing Home, Long Preston ...	—	—	10	Generally hospital convalescent cases
Sunnybank Nursing Home, Braithwaite, Keighley ...	—	—	6	
Blue Dawn Nursing Home, Priesthorpe Lane, Bingley ...	—	12	—	
Elmhurst Nursing Home, Hall Bank Drive, Bingley ...	—	—	6	
Thornfield Nursing Home, Micklethwaite, Bingley ...	—	2	8	
Chevin Hall Nursing Home, Chevin Hall, Otley ...	35	—	—	
Fairholme Nursing Home, Hebers Ghyll Drive, Ilkley ...	—	—	14	
Jesmond Nursing Home, New Street, Farsley	—	—	7	
St. Joseph's Convalescent Home, Outwood Lane, Horsforth ...	—	—	45	
West Leigh Nursing Home, Pool in Wharfedale ...	—	—	4	
Alderson Nursing Home, 2 Alderson Square, Harrogate ...	—	—	6	
Alexandra Nursing Home, 7 Alexandra Road, Harrogate ...	—	—	3	
Beech Grove Nursing Home, 1 Beech Grove, Harrogate ...	—	—	8	
Cavendish Nursing Home, 17 Cavendish Avenue, Harrogate ...	—	—	7	
Clova Nursing Home, Clothierholme Road, Ripon ...	—	—	21	
Courtfield Nursing Home, 3 St. James Drive, Harrogate ...	—	—	14	Operating theatre, X-rays, pathological investigations
Duchy House Clinic, 9 Queen's Road, Harrogate	—	5	30	
Ellangowan Nursing Home, 26, Queen's Road, Harrogate ...	—	—	8	
Hereford Nursing Home, 16 Hereford Road, Harrogate ...	—	—	21	
Kingsley Nursing Home, 38 Ripon Road, Harrogate ...	—	—	12	
Norman Lodge Nursing Home, 58 Kent Road, Harrogate ...	—	—	25	No further admissions to be made
Nursing Home, 2 East Park Road, Harrogate	—	—	2	
Strathroy Nursing Home, 115 Franklin Road, Harrogate ...	—	—	8	
The Pines Nursing Home, 57 Harlow Moor Drive, Harrogate ...	—	—	14	
Ure Lodge Nursing Home, Ure Bank Terrace, Ripon ...	—	—	21	

Name and Address of Nursing Home	No. of Beds Registered			Other Information
	Mental	Maternity	Other	
Westfield Nursing Home, Killinghall, Harrogate	—	—	7	
Windermere Nursing Home, 1a Westcliffe Grove, Harrogate	—	—	1	
Cheshire Foundation Home, Spofforth Hall, Spofforth	—	—	21	
Benton Nursing Home, Benton Hill, Horbury	—	6	—	
Kenmore Nursing Home, Whitcliffe Road, Cleckheaton	—	—	15	
Cross Brook Nursing Home, Burnley Road, Todmorden	—	—	8	
Cheshire Foundation Home, White Windows, Sowerby Bridge	—	—	35	
Woodend Nursing Home, Atherton Street, Springhead	—	—	13	
Glen Haven Nursing Home, 35 Cusworth Lane, Sprotborough	—	—	2	

NOTIFICATION OF BIRTHS

(*Public Health Act, 1936, Section 203*)

Notifications were received relating to 21,188 live and still births occurring in the Administrative County Area, and of 11,685 births occurring elsewhere to mothers who were normally resident in the County. The former figure included 2,743 births to mothers not normally resident in the County Area, and the consequent net total of births notified and attributable to the County Area was 30,130. When this figure is compared with the Registrar General's return of 30,353 births (29,792 live and 561 still births) in the County Area, the degree of error is slight and affords satisfactory evidence of the system of notification.

Prompt notification makes it possible to arrange for the early visitation of the newly-born babies by health visitors and it is satisfying to record that 30,688 first visits to children under one year of age were made by health visitors.

NURSERIES AND CHILD-MINDERS REGULATION ACT, 1948

At the end of the year, there were 8 nurseries registered for the care of 177 children and 19 child-minders registered for the care of 97 children. Seventy-five visits of inspection were made.

MEDICAL ARRANGEMENTS FOR COUNTY CHILDREN'S HOMES AND RESIDENTIAL NURSERIES

Divisional Medical Officers have submitted periodic reports on the discharge of their responsibilities for the medical arrangements at County Children's Homes and Residential Nurseries; these provide for the medical examination of children on admission and discharge, subsequent routine and special examinations, the keeping of medical records, precautions against the spread of infectious diseases, determining the hours of rest and sleep, the general supervision of health, hygiene and dietary, and the staffing of the nurseries. Routine examinations, which are undertaken monthly in residential nurseries and six-monthly in children's homes, reveal the not-unexpected high proportion of children with physical and mental defects, and with emotional problems.

MEDICAL EXAMINATION FOR SUPERANNUATION

During the year 227 medical examinations were carried out under the old scheme, when all applicants were examined and Form Med.4 completed. These were classified as follows:—

<i>Approved</i>	<i>Not Approved</i>	<i>Deferred</i>
220	6	1

216 of these examinations were carried out by the County Council's medical officers, 2 by medical officers of other local authorities, and 9 by general practitioners.

The revised arrangements, approved by the County Council on the 17th January, 1962, came into operation towards the end of February. Under these arrangements prospective entrants to the scheme are required to complete a questionnaire dealing with personal and family medical history, the need to complete the questionnaire truthfully being impressed on the applicant by the inclusion of a notice indicating that failure to do so may prejudice employment. A "confidential" reply paid envelope is provided. On the information obtained from the questionnaire a decision is made as to whether a medical examination will be undertaken. The following categories are required to have a full medical examination irrespective of the information given in the questionnaire:—

- prospective entrants over the age of 45 years.
- applicants whose prospective employment is such that public safety is involved e.g., Fire and Ambulance Service drivers.

The questionnaire and/or medical examination is regarded as a suitable basis for recommendations to heads of departments on the possible eligibility of employees for registration as disabled persons.

Applicants already admitted into a local government superannuation scheme are automatically admitted to the County Council's scheme without any form of medical screening provided that superannuable service is continuous, the employing department having the responsibility of enquiring into the sickness record of such applicants.

During the year 1,247 health questionnaires were received. Of this number 806 (64.63 per cent.) were approved for admission to the superannuation scheme on the basis of the information obtained from questionnaires.

441 applicants were referred for medical examination as follows:—

<i>Reason for medical examination</i>	<i>Number examined</i>	<i>Approved</i>	<i>Not Approved</i>	<i>Deferred</i>
Age only (applicants over 45 years of age)	160	153	4	3
History only (applicants under 45 years of age)	157	143	6	8
Category of employment (e.g., Driver)	32	32	—	—
Age and History	67	44	20	3
Age and Category	7	6	1	—
History and Category	15	13	—	2
Age, History and Category	3	3	—	—
	441	394	31	16

420 of these examinations were carried out by the County Council's medical officers, 11 by medical officers of other local authorities, and 10 by general practitioners. 30 specialist reports were obtained. It is interesting to note that, although the number of medical examinations was reduced under the revised scheme by approximately 65—70 per cent., the number of applicants rejected was about the same. This suggests that the new procedure is both time-saving and efficient.

During the year 63 special medical examinations were carried out by the authority's medical officers at the request of employing departments.

17 requests for medical examination were received from other local authorities.

WEST RIDING DISTRESS FUND

Grants from the West Riding Distress Fund were made in 12 cases as follows:—

- 5 For travelling expenses to enable relatives to visit patients undergoing hospital treatment.
- 2 Items of furniture provided for Mental Health patients.
- 3 For the provision of clothing for Mental Health patients.
- 1 For the provision of food for a woman living alone.
- 1 For the payment of an electricity account for a family in financial difficulties.

PART VII

THE HEALTH OF THE SCHOOL CHILD

**The Annual Report of the Principal School
Medical Officer**

including

**The Report of the Principal School Dental
Officer**

and

**The Report of the School Medical Officer to
the Keighley Excepted District**

THE HEALTH OF THE SCHOOL CHILD

(Being the 55th Annual Report of the Principal School Medical Officer)

Introduction:

The year has been one of consolidation rather than the introduction of new schemes or major changes in the School Health Service. New ventures introduced in the preceding year, e.g., non-routine medical inspections, audiology clinics and the increased emphasis on early diagnosis of hearing loss were allowed to get under way and are already bearing their first fruits.

The routine medical inspection of school children continues as the main springboard from which the various branches of the School Health Service operate. All school children are given a routine medical inspection in the year of entry and again in the last year at school. In most Divisions routine examinations are also given to all children in the 7-8 year and 11-12 year age-groups. In other Divisions, however, the 7-8 years and 11-12 years examinations are replaced by the screening method whereby a questionnaire (Health Summary) is sent to the parents and the necessity for a detailed physical examination is decided on the evidence provided by the questionnaire and from discussions between the medical, nursing and teaching staff. The confidential nature of the Health Summary, which is reproduced as Appendix I to this Report, has encouraged parents to bring to light worries about their children which they might otherwise have kept to themselves. The results of this scheme have proved so encouraging that the Divisional, School Health and Dental Services Sub-Committee have agreed that it can be adopted in any Division where the Divisional Medical Officer feels that local conditions make it possible and desirable. The Health Summary is also being used as a basis for the revision of the Form N.P. which is used to advise parents of the routine medical inspection.

Continued progress was made in the field of audiology. The two clinics established in 1961 at Doncaster and Horsforth are now receiving a steady flow of cases. The Horsforth Clinic serves the northern half of the County and cases from the southern half attend the Doncaster Clinic. There is an increased emphasis on audiometry and School Medical Officers now apply an audiometric test to all children who are reported as being backward at school. Also, children in certain 'at risk' categories are tested as are all children in the 6-7 year age group. Full details of this scheme and of the work done at the Audiology Clinics are given in the section headed 'The Deaf and Partially Hearing Child'.

Probably the most important development has been in the Child Guidance Service. A difficult situation threatened when the Leeds Regional Hospital Board indicated that they were unlikely to be able to replace the services of Consultant Psychiatrists who left the Region. This actually materialised when Dr. W. M. Burbury, who covered the Shipley and Skipton Clinics, retired. By goodwill and co-operation on both sides, however, a solution to the problem was found and agreement was reached to a policy whereby a Senior Assistant County Medical Officer, Dr. Atkinson, would be engaged in Child Guidance work, with consultant cover to Dr. Atkinson's clinics being provided from clinics where a Consultant Psychiatrist is in attendance. This is an encouraging development and it may well lead to an ultimate increase in the number of clinics provided so reducing the load on present clinics and the distances involved when patients have to travel from remote areas. A full report on the service and on the work of the individual clinics is given under the heading 'The Maladjusted Child'.

The practice of selling sweets and biscuits in schools continues to give cause for concern. There has been only slight improvement in this direction and a positive lead from the Committee will have to be given before any real progress can be made.

With regard to medical staffing, resignations and retirements were rather heavier than usual but eleven new appointments were made and the year closed with a slightly stronger staffing position than obtained in January. It will be seen, however, that eleven new appointments in a whole-time staff of 57 Assistant County Medical Officers show a twenty per cent. turnover of staff and, as many of the new staff have very little Public Health experience, it is essential to maintain a high rate of attendances on the various post-graduate courses which are available. This is supported by the Consultant Pædiatrician, Dr. Harvey, who, in his report to me, comments as follows:—

“The work of a consultant should be progressive and educational, not merely a programme of ad-hoc problem-solving for hospitals and general practitioners and clinic doctors. It should be the case that each consultation, whether in presence or by letter, leads to such an exchange of knowledge and wisdom that both parties are the better able to solve their own problems independently in the future. I gratefully acknowledge how much I myself gain every year from the consultations which doctors afford to me, both in our County clinics and in hospital or domiciliary work, not forgetting the informative value of the monthly conference at County Hall. I trust similar help adheres in the minds of the doctors I work with. It comes home to me whenever a new locum or assistant joins a family practice, and he sends me an assortment of minor puzzles which his more experienced seniors would take in their stride without needing a second opinion.

A similar process is present in the work of Assistant County Medical Officers and their part-time colleagues. When we are recently qualified we lack both the knowledge and the experience to deal with the wide variations of both normal and diseased states. Medical education is a progressive matter, of which only the minimum foundation has been laid by the time we become registered. Progress in published research and debate requires all of us who are senior to devote time to keeping abreast of new knowledge, so that we may apply it in our work and may correct the misapprehensions under which we have laboured. If it is required by law of midwives to undertake refresher courses every five years, there is a more important requirement that doctors with their greater responsibility shall keep even more actively up to date by study courses. For the rest of the time, consultants' discussion at clinics and their letters to doctors should be as detailed, informative and educative as time and energy permit.”

One very interesting and valuable feature last year was a week-end course at Grantley Hall run jointly for Assistant County Medical Officers and Head Teachers. It was felt that it would be particularly helpful to have a course where Assistant County Medical Officers and Head Teachers could come together for a series of lectures on matters of common interest. This, indeed, proved to be the case when twenty-five Assistant County Medical Officers and twenty-five Head Teachers met at Grantley in May. Lectures were given by Dr. Elizabeth Gore, Consultant Child Psychiatrist, on ‘The Family Constellation and Parental Attitudes’; by Mr. H. Davies, Headmaster of the High Pavement School, Nottingham, on ‘Help and Hindrances to Learning within the School’; by Dr. P. H. Connell, Medical Director of the Child Psychiatric Unit, Newcastle General Hospital, on ‘Psychological Problems in the Normal Child and Adolescent’; and by Mrs. H. V. Wilkinson, Headmistress, Blenheim County Secondary Girls’ School, Leeds, on ‘Education for Health’. It was evident that, not only were the lectures greatly appreciated, but also that a most valuable part of the week-end was the exchange of views as teachers and doctors mingled informally in the social intercourse which is an integral part of a course at Grantley.

Dr. A. Marshall, Senior Medical Officer, School Health, retired at the end of July and, for the remainder of the year, medical oversight of the School Health Service was given by the Deputy County Medical Officer, Dr. Lyons.

Once again I would record my appreciation of the full co-operation given by the Chief Education Officer and his staff and by the school teachers, who accept the many interruptions to their class work in a most sympathetic manner.

The Medical Inspection of School Children:

The number of pupils on the registers is as follows:—

	<i>Boys</i>	<i>Girls</i>	<i>Total</i>
Nursery... ..	285	316	601
Primary (County)	61,923	58,663	120,586
Primary (Voluntary)	21,154	19,914	41,068
Secondary Modern (County)... ..	27,181	24,937	52,118
Secondary Modern (Voluntary)	1,491	1,603	3,094
Secondary Grammar	12,787	12,865	25,652
Secondary Technical	1,222	1,399	2,621
Comprehensive	6,223	5,913	12,136
Bi and Multi Lateral Secondary	1,124	967	2,091
Special Schools	588	404	992
	<u>133,978</u>	<u>126,981</u>	<u>260,959</u>

TABLE I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS)

A.—Periodic Medical Inspections

Age groups inspected (by year of birth) and number of pupils examined in each, together with classification of the physical condition of the pupils inspected.

Age groups inspected (Year of Birth)	Number of pupils inspected	Satisfactory		Unsatisfactory	
		No.	% of Column 2	No.	% of Column 2
1958 and later ...	1,174	1,165	99.23	9	0.77
1957 ...	12,190	12,112	99.36	78	0.64
1956 ...	9,306	9,256	99.46	50	0.54
1955 ...	5,356	5,326	99.44	30	0.56
1954 ...	9,167	9,124	99.53	43	0.47
1953 ...	4,593	4,570	99.50	23	0.50
1952 ...	2,391	2,377	99.41	14	0.59
1951 ...	7,758	7,708	99.36	50	0.64
1950 ...	5,444	5,413	99.43	31	0.57
1949 ...	1,747	1,739	99.54	8	0.46
1948 ...	8,391	8,345	99.45	46	0.55
1947 and earlier...	14,878	14,815	99.58	63	0.42
Total ...	82,395	81,950	99.46	445	0.54

B.—Other Inspections

Number of Special Inspections	...	18,152
Number of Re-Inspections	...	9,042
Total	...	27,194

C.—Pupils Found to Require Treatment

Number of individual pupils found at Periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Group (Year of Birth)	For defective vision excluding squint	For any of the other conditions recorded in Table III	Total individual pupils
1958 and later	13	117	123
1957	320	1,135	1,389
1956	272	816	1,042
1955	202	467	627
1954	445	821	1,181
1953	200	316	483
1952	110	178	273
1951	328	538	814
1950	270	339	583
1949	112	110	201
1948	319	505	792
1947 and earlier	745	843	1,516
Total	3,336	6,185	9,024

TABLE II

INFESTATION WITH VERMIN

(i)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	...	421,257
ii)	Total number of <i>individual</i> pupils found to be infested	...	8,912
ii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	...	176
v)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	...	45

TABLE III

DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31ST DECEMBER, 1962

NOTE.—All defects noted at medical inspection as requiring treatment are included in this table,
whether or not this treatment was begun before the date of the inspection

Defect Code No.	Defect or Disease	PERIODIC INSPECTIONS						SPECIAL INSPECTIONS	
		Entrants		Leavers		TOTAL (including all other periodic age groups inspected)		Requiring treatment	Requiring observation
		Requiring treatment	Requiring observation	Requiring treatment	Requiring observation	Requiring treatment	Requiring observation		
4	Skin	191	425	337	379	950	1,383	338	314
5	Eyes—	676	1,536	1,029	2,464	3,336	7,527	1,004	3,012
	a. Vision	261	417	43	171	433	1,061	88	311
	b. Squint	37	84	34	113	139	342	63	69
6	Ears—	89	452	52	159	273	1,056	109	381
	a. Hearing	121	404	45	189	295	959	63	256
	b. Otitis Media	38	109	33	37	135	239	57	46
	c. Other	533	1,979	87	360	1,039	3,985	244	1,149
7	Nose and Throat	221	534	18	71	425	916	328	395
8	Speech	53	749	6	89	95	1,352	22	301
9	Lymphatic Glands	20	413	27	241	83	1,133	41	374
10	Heart	114	759	34	240	245	1,669	103	647
11	Lungs	18	89	21	42	63	221	20	89
12	Developmental—	29	445	26	145	146	1,266	56	419
	a. Hernia								
	b. Other								
13	Orthopaedic—	17	96	37	162	128	482	29	113
	a. Posture	209	549	102	320	557	1,523	118	487
	b. Feet	76	536	89	307	276	1,365	97	382
	c. Other								
14	Nervous System—	9	48	17	35	43	168	38	90
	a. Epilepsy	118	236	32	70	219	528	56	184
	b. Other								
15	Psychological—	17	191	18	87	91	596	294	371
	a. Development	54	489	16	142	137	1,102	134	495
	b. Stability	19	83	15	54	66	261	17	72
16	Abdomen	239	298	220	276	862	962	527	425

TABLE IV
TREATMENT OF PUPILS

Notes

The figures given under this heading include:—

- (i) cases treated or under treatment during the year by members of the Authority's own staff;
- (ii) cases treated or under treatment during the year in the Authority's school clinics under National Health Service arrangements with the Regional Hospital Board;
- (iii) cases known to the Authority to have been treated or under treatment elsewhere during the year.

Group 1. Eye Disease, Defective Vision and Squint

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	771
Errors of refraction (including squint)	19,103
Total ...	19,874
Number of pupils for whom spectacles were prescribed ...	8,831

Group 2. Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been treated
Received operative treatment:—	
(a) for diseases of the ear	32
(b) for adenoids and chronic tonsillitis	1,014
(c) for other nose and throat conditions	50
Received other forms of treatment	697
Total ...	1,793

Total number of pupils in schools who are known to have been provided with hearing aids:—

(a) in 1962	49
(b) in previous years	190

Group 3. Orthopædic and Postural Defects

	Number of cases known to have been treated
(a) Pupils treated at clinics or out-patient departments	509
(b) Pupils treated at school for postural defects ...	5
Total ...	514

Group 4. Diseases of the Skin (excluding uncleanliness for which see Table II)

Ringworm—(a) Scalp	6
(b) Body	12
Scabies	63
Impetigo	334
Other skin diseases	2,214
Total ...	2,629

Group 5. Child Guidance Treatment

Number of pupils treated at Child Guidance clinics under arrangements made by the Authority	757
--	-----

Group 6. Speech Therapy

Number of pupils treated by Speech Therapists under arrangements made by the Authority	2,429
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Group 7. Other Treatment Given

(a) Number of cases of miscellaneous minor ailments treated by the Authority	14,426
(b) Pupils who received convalescent treatment under School Health Service arrangements	79
(c) Pupils who received B.C.G. vaccination	12,020
(d) Other:—	
1. Ultra Violet Light Treatment	485
2. Audiology	95
3. Chiropody	184

Total (a)—(d) ... 27,289

Care of the Handicapped Child:

One of the most important aspects of the School Health Service is the ascertainment of handicapped children and the School Medical Officer must, of necessity, have a detailed knowledge of the Handicapped Pupils Regulations in addition to a wide experience of the various categories of handicap which occur in children. He must ensure that children who deviate from the normal are recommended for the special educational treatment best suited to their physical and mental condition.

In order to keep abreast of the many changes in statutory procedure and the present-day trends in prevention, diagnosis and treatment, periodic attendance at Ministry-approved post-graduate courses of instruction is essential. The three-week course for School Medical Officers on the ascertainment of sub-normality is of especial importance, since approval to undertake this work cannot be given without attendance. The number of new ascertainments and re-examinations undertaken during 1962 was 1,830 compared with 1,691 the previous year. Details are as follows:—

Category	No. of examinations and re-examinations
Educationally sub-normal	1,149
Physically handicapped	324
Delicate	163
Deaf	21
Partially hearing	18
Epileptic	47
Speech (requiring special school)	—
Maladjusted (requiring hostel or special school)	54
Blind	4
Partially sighted	22
Double defect	28
Total ...	1,830

The following table gives details of handicapped pupils and placings in special schools and hostels during the year, and particulars of the number of children in residence in special schools at the end of the year:—

Category	New Ascertainments	New Placings in Special Schools	Total No. attending Special Schools		No. Boarded in Homes or Hostels	No. Attending Independent Schools	No. Awaiting Placement in Special Schools	No. receiving Home Tuition
			Day	Board- ing				
Blind	4	—	—	41	—	—	7	—
Partially Sighted	13	5	17	34	—	—	12	—
Deaf	14	12	46	132	—	—	2	—
Partially Hearing	7	4	17	29	—	—	2	—
Delicate	48	41	40	91	1	—	16	1
*Physically Handicapped	45	44	34	111	—	12	23	40
Educationally Sub-normal	271	216	670	270	—	10	365	2
Maladjusted	24	18	—	26	25	2	10	—
Epileptic	12	9	—	25	—	—	3	—
Speech Defects	1	2	3	3	—	—	2	—
Totals	439	351	827	762	26	24	442	43

* Excluding children sent to or awaiting places in hospital schools. At the end of the year there were 153 children on the registers of hospital special schools.

It is encouraging to note a slight but steady improvement in the position relating to the placement of pupils in special schools. Wherever possible handicapped pupils are placed in the Authority's special schools, a full list of which is given below. If placement in one of the Authority's special schools is not possible, an appropriate vacancy is sought in schools operated by other authorities or voluntary organisations, providing these schools appear in the Ministry of Education approved list.

West Riding Special Schools

	<i>Age range (years)</i>	<i>Accommodation</i>
Residential Special Schools for Delicate Children		
Ingleborough Hall, Clapham	6—12	50 mixed
Netherside Hall, Skipton in Craven	11—16	40 boys
Day Special School for Delicate Children		
Stile Road, Todmorden	All ages	60 mixed
Residential Special School for Deaf and E.S.N. Boys		
Bridge House, Harewood	9—16	40 boys
Residential Hostel for Maladjusted Boys		
Nortonthorpe Hall, Scissett	9—16	25 boys
Residential Special Schools for E.S.N. Children		
Baliol School, Sedbergh	11—16	56 boys
Royd Edge School, Meltham	11—16	54 girls
Springfield School, Horsforth	7—11	51 mixed
Whinburn School, Keighley	7—11	44 mixed
Day Special Schools for E.S.N. Children		
Heaton Royds School, Shipley	Juniors	100 mixed
John Street School, Wombwell	Juniors	60 mixed
Hartshead Moor School, Cleckheaton	All ages	100 mixed
Milton School, Swinton	All ages	100 mixed
Castle School, Pontefract	All ages	100 mixed
Braithwaite School, Keighley	All ages	100 mixed

THE PHYSICALLY HANDICAPPED CHILD:

Cerebral palsy continues to be a serious cause of physical defect in children.

Particulars of educable cerebral palsied children in the County are given below. The figures include children of pre-school age.

Total No. of educable Spastics	No. accommodated in Special Schools	No. attending Ordinary Schools		No. receiving Home Tuition	No. receiving no Education
		Satisfactorily	Needing placement in Special Schools		
187	93	55	34	2	3

THE DELICATE CHILD:

The decline in the numbers of children reported in this category during recent years continues and the number of new ascertainties during 1962 was 48 compared with 81 in the previous year. There has been a corresponding reduction in the waiting list for admission to the residential special schools and only 16 children were awaiting placement at the end of the year.

Delicate children recommended for admission to the Authority's Boarding Open Air Schools are mainly cases of bronchitis, bronchiectasis, or asthma, with an occasional case of debility due to poor home management.

Dr. Harvey, part-time Pædiatrician to the West Riding, visits Ingleborough Hall and Netherside Hall with the Senior Medical Officer of the School Health Service twice yearly. His help and advice are always greatly appreciated.

THE BLIND AND PARTIALLY SIGHTED CHILD:

Children who may be blind or partially sighted are examined by an ophthalmologist of consultant status. The school medical officer also examines the children for any additional handicaps.

THE DEAF AND PARTIALLY HEARING CHILD:

The two audiology clinics opened in 1961 at Doncaster and Horsforth are now well established and there is a steady flow of cases to these clinics. The Doncaster Clinic is held at the Yorkshire School for the Deaf where, by the courtesy and kindness of the Headmaster, Dr. Greenaway, a room and equipment have been made available. The Horsforth Clinic is held in the Child Welfare Centre but it is intended that this clinic will move to new premises nearing completion at Otley where a soundproof room will be available. A full team of Clinic Medical Officer, Psychologist, Teacher of the Deaf, Speech Therapist and Health Visitor is in attendance at each clinic.

Careful screening of both school children and pre-school children is carried out in the local Health Divisions and the children referred for investigation at the audiology clinic are those in whom some hearing loss has already been suspected. Forty-eight Health Visitors have received special training in methods of detecting hearing loss in young babies and their vigilance has resulted in the ascertainment of deafness in several cases at an early age. It is, of course, of the utmost importance that cases of suspected hearing loss be investigated at the

earliest possible age. The screening of older children is carried out by means of pure-tone audiometry. Eighteen pure-tone audiometers are now in use but with twenty-three Health Divisions a certain amount of sharing is still necessary. This should, however, be rectified in the near future. The agreed policy is to carry out a routine audiometric test on all children in the 6-7 year age group (i.e., as soon as possible after the sixth birthday) and on all children who have been subjected to adverse influences that may cause impairment of hearing. These children are known as the 'at risk' group and include the following categories:—

Children with a family history of deafness.

Children with otorrhœa.

Children suffering from athetosis.

Children who had perinatal abnormalities, e.g., asphyxia, rhesus incompatibility, especially kernicterus.

History of German measles or other virus infection in the first two months of pregnancy.

Prematurity.

Children who had a severe illness, e.g., meningitis or any who have been treated with streptomycin.

Children with speech defects or suffering from delayed onset of speech.

In addition it is hoped that all children failing to make progress at school or all who are found to be educationally sub-normal would have the possibility of hearing loss investigated.

Dr. Ferguson reports as follows on the *Doncaster Clinic*:—

“ The number of sessions of the Audiology Clinic was increased to 16 in 1962 and a further expansion will be necessary as the screening of 'at risk' children proceeds.

Apart from the difficulties thrown up by the cases of hearing defect due to catarrhal conditions, the cases which require a hearing aid, and the cases which require education in a school for the deaf, two other activities of the assessment clinic are important:—

1. Parent Guidance.

It cannot be too strongly emphasised that parents, particularly mothers, must be guided and advised with regard to the home training of a child as soon as deafness is suspected. Simple instructions are given as to constant repetition of words to the child in meaningful situations, thus training the child to look and listen. Where a hearing aid is provided, advice is necessary on the need for speaking clearly and distinctly near the microphone, and where the child can also see the speaker's face and lip movements. These discussions with parents take time but it is time well spent, not only for the child's benefit, but also it reassures the parents that with their help and co-operation the effect of the handicap can be reduced.

2. Speech Audiometer.

A completed report on a child, in addition to an audiogram, includes a report on:

- (a) Understanding for speech
- (b) Understanding of language
- (c) Use of spoken language

Whilst the pure tone audiometer is invaluable in an assessment clinic it must not be forgotten that it is not sound but words which are important in hearing. Whenever possible the speech audiometer is used on children, and has proved most helpful in the final assessment of the educational and other needs of the child. Consideration is now being given to improving if possible the selection of words on the present records.”

A statistical summary of the work carried out at the Doncaster Audiology Clinic is as follows:—

No. of sessions held: ...	...	...	...	...	...	...	...	16
No. of individual children attending:								
(a) referred for first time in current year: ...	...	...	...	...	...	...	...	55
(b) also attended in previous year: ...	...	...	...	...	...	...	...	9
Total								64
Total number of attendances made:...								75

Areas from which referred (i.e., number from each Division):

Goole	...	...	...	...	...	3
Pontefract	...	...	...	...	...	2
Wortley	...	...	...	...	...	1
Hemsworth...	...	...	...	...	...	7
Barnsley	...	...	...	...	...	1
Wath	...	...	...	...	...	23
Doncaster	...	...	...	...	...	13
Thorne	...	...	...	...	...	4
Rotherham...	...	...	...	...	...	1
						55

Ages of children referred:

Under 1	...	...	...	...	...	—
1– 2 years...	...	...	...	...	...	2
2– 5 years...	...	...	...	...	...	4
5– 8 years...	...	...	...	...	...	15
8–11 years	...	...	...	...	...	18
11 + years	...	...	...	...	...	16

Results of Clinical Investigation:

No. of children with significant hearing loss: ...	...	...	...	...	26
No. of children without significant hearing loss: ...	...	...	...	...	29

Recommendations:

Hearing aid recommended: ...	...	...	...	...	...	...	13
To sit in front of class: ...	...	...	...	...	...	...	13
Speech Therapy recommended: ...	...	...	...	...	...	...	6
School for Deaf recommended: ...	...	...	...	...	...	...	3
School for Partial Hearing recommended: ...	...	...	...	...	...	...	—
School for Speech Defects recommended: ...	...	...	...	...	...	...	—
Referred to E.N.T. Consultant: ...	...	...	...	...	...	...	6
Special School with Speech Therapy: ...	...	...	...	...	...	...	1

Dr. Burn reports as follows on the *Horsforth Clinic*:

“ During the year we were without the services of Mr. Rees for some months owing to illness, but children were seen by the other members of the team, and assessments and special treatments made, except that hearing aids could not be prescribed directly.

Thirty-one new cases were referred during the year, eighteen from other divisions and thirteen from this division. This in part reflects the difficulty of travel to a central audiology clinic, but it is also influenced by the fact that, if specialist otological treatment is all that is required, children have to be sent to the nearest E.N.T. hospital clinic, and the problem of double responsibility arise. While it is highly desirable that all school children wearing hearing aids should be followed up through the audiology clinic, where these aids have been provided by another unit, that unit naturally likes to do the follow-up.

Of the thirty-one cases seen, twenty-one had no significant hearing loss from an educational standpoint. Most of these were children referred for an opinion as to whether hearing loss was contributing to educational retardation. Now that audiometers are available in each division, it is likely that some of these will be screened before reaching the clinic in future. The advantage of having a psychologist on the staff is often apparent in these cases, as comparisons can be made between the verbal and non-verbal responses of the child which are helpful in assessing the disposal of the case. We are now sceing, for review, children who have been supplied with hearing aids, and this work will undoubtedly grow in the future.

Surprisingly we are not having many pre-school children referred, despite the screening tests which are being carried out by the specially trained Health Visitors. Experience in other parts of the country suggests a higher incidence of congenital deafness than has become apparent from our findings. It will be interesting to see whether this side of the work, for which we are specially equipped, increases as people become more aware of the value of early detection of deafness in children.”

A statistical summary of the work carried out at the Horsforth Audiology Clinic is as follows:—

<i>No. of sessions held:</i> ...	...	...	...	...	...	...	...	9
<i>No. of individual children attending:</i>								
(a) referred for first time in current year:	...	...	...	...	...	...	...	30
(b) also attended in previous year:	...	...	...	...	...	...	...	1
Total								31
<i>Total number of attendances made:</i>...	...	...	...	...	...	...	...	33

Areas from which referred (i.e., number from each Division):

Skipton	...	...	...	...	...	1
Shipley	...	...	...	...	...	7
Horsforth	...	...	...	...	...	13
Wetherby	...	...	...	...	...	1
Batley	...	...	...	...	...	1
Spenborough	...	...	...	...	...	3
Brighouse	...	...	...	...	...	4
Colne Valley	...	...	...	...	...	1
						31

Ages of children referred:

Under 1	...	...	...	...	...	—
1– 2 years	...	...	...	...	...	—
2– 5 years	...	...	...	...	...	2
5– 8 years	...	...	...	...	...	13
8–11 years	...	...	...	...	...	5
11 + years	...	...	...	...	...	11

Results of Clinical Investigation:

No. of children with significant hearing loss	...	...	...	...	10
No. of children without significant hearing loss	...	...	...	...	21

Recommendations:

Hearing aid recommended	...	...	...	...	...	5
To sit in front of class	...	...	...	...	...	4
Speech Therapy recommended	...	...	...	...	...	1
School for Deaf recommended	...	...	...	...	...	—
School for Partially Hearing recommended	...	...	...	...	...	—
School for Speech Defects recommended	...	...	...	...	...	—

THE EPILEPTIC CHILD:

The increased medical knowledge of epilepsy and the availability of drugs which control the seizures has brought a lessening in the demand for places in special schools for epileptic children. It is now possible to retain in ordinary schools many of the children who, previously, have been cases for admission to residential establishments.

THE EDUCATIONALLY SUB-NORMAL CHILD:

Of all handicapped children, the larger proportion, by far, fall within this category and, of a grand total of 2,124 handicapped pupils recommended for special educational treatment, 1,307 are educationally sub-normal. The rate of ascertainment has been stepped up considerably over recent years but the total of 1,307 educationally sub-normal children ascertained as needing special educational treatment in special schools represents only half of one per cent. of the total school population, or approximately five per thousand. From evidence available it would appear that full ascertainment would reveal a higher ratio than this and it will be seen, therefore, that the ascertainment of educationally sub-normal children is a field which can be expanded considerably and which offers challenging, interesting and fascinating work.

It is encouraging to note a great improvement in the placing of educationally sub-normal children as shown by the following comparative figures for the years 1951, 1956 and 1962.

Educationally Sub-normal Children

	New Ascertainments	Total No. attending Special Schools		No. awaiting placement in Special Schools	Total	Per- centage placed
		(Day)	(Boarding)			
1951	282	18	111	666	795	16
1956	194	184	335	539	1,058	49
1962	271	670	270	365	1,295	72

The provision of a new Day Special School in the Don Valley area, envisaged for 1964, will effect a further improvement in the position.

During the year 140 children were reported to the Local Health Authority as being ‘unsuitable for education in school’ and 134 children as requiring care and guidance have been referred informally to the Mental Health Section of the Authority.

Care of School Leavers:

All educationally sub-normal children are examined as they approach school leaving age to determine whether or not they need care and guidance after leaving school. There is, of course, no legal insistence for this procedure although it is recommended in the Ministry of Education Circular 12/60, wherein it is stated ‘Although statutory reports will no longer be issued, local education authorities can pass to local health authorities information on school leavers who they think will require care or guidance, and it is obviously desirable that they should do so’ (para. 26).

As these children approach their last term at school, Divisional Medical Officers are asked to report as to whether or not care and guidance is recommended. If the last Form 2 HP was completed more than three years ago, an up to date Form 2 HP is requested for cases recommended for care and guidance.

The Mental Welfare Officer personally delivers a letter from the Chief Education Officer to the parents of children recommended for care and guidance. This letter offers care and guidance and if the offer is accepted the child is placed on the list for visits by the Mental Welfare Officer. It is, in effect, an offer of assistance which cannot be enforced. In practice it is found that most of the parents of educationally sub-normal children welcome this offer of help and are glad of the advice and assistance the Mental Welfare Officer is able to give.

CHILDREN WITH SPEECH DEFECTS:

Children with speech defects are normally referred to the speech therapist by the school medical officer and there is good liaison between school medical officers, school teachers and speech therapists.

The Authority has an establishment of eighteen speech therapists and the number employed at the end of the year was thirteen whole-time and three part-time.

The following interesting reports of speech therapy on the district have been submitted by three members of the County staff:—

Mrs. K. Harrison reports on work in the Skipton Division as follows:—

“ One of the early difficulties in this Division was to decide where to start clinics and, once this had been settled, to find suitable accommodation. In this respect the schools were most co-operative and clinics now function in three County Secondary Schools and two large Junior Schools. This is in addition to the clinics in Skipton, Settle and Barnoldswick.

Co-operation from the teachers in these schools has been excellent and, as a result, progress of these children appears in some cases to have been better than those children attending a clinic with parents. This is probably due to the fact that the teachers have realised more fully the aims of speech therapy and, as a result, the children have received help during the normal school programme.

Transport in a rural area is difficult but seems to have been overcome in most places.

The waiting list is only very long for two clinics and one of these has only been in operation for a year, so the position here may gradually improve. This is probably due to the fact that some children are only receiving fortnightly treatment, and some five year olds have been left for six months after having one interview during which advice was given to the parents. This is not an ideal arrangement but does avoid an urgent case being left on the waiting list an unnecessarily long time.

One of the most interesting cases in this Division during the last two years has been that of David M. (9.2.52). After two years' speech therapy very little progress had been made and it was decided to send him to the diagnostic section of Moor House School. After investigation there he was found to have developmental dysphasia, primarily receptive, and, as a result, was admitted for residential treatment. He was last seen in December, 1962, by the S.A.C.M.O. and was found to have made excellent progress at the school. Speech is now intelligible and comprehension of spoken language improving.

Another interesting case was that of Grace R. aged 5 years. She was an intelligent child but had such a severe dyslalia that her speech was completely unintelligible. Her teacher was extremely anxious for her to attend for speech therapy as she felt that her speech disorder was holding her back in every way. She was admitted for treatment and in three months had almost normal speech. The progress made was quite remarkable in a child so young, particularly as the mother was unco-operative in many ways and did not seem to think her child's severe speech defect in any way unusual.”

Mrs. S. C. Holmes, Speech Therapist in the Wortley and Barnsley Divisions, reports on her work in the following terms:—

“ In the Wortley Division (the more rural of the two Divisions) infrequent bus services, long journeys and serious loss of school time did not encourage a regular attendance for treatment. However, the use of a car for travelling has, during 1962, enabled me to establish two new centres for treatment thus bringing the service to the patients. This has resulted in less school time lost, a much better attendance record and consequently more rewarding results of therapy. There remains the occasional child for whom regular speech therapy is impossible for various reasons. In one such case, advice to the parents and teacher, with whom there was a good liaison, has resulted in a satisfactory standard of speech.

During October, 1962, a colleague and myself attended the Northern Area Refresher Course (organised by the College of Speech Therapists) along with some one hundred and twenty other therapists from all over the country. This four day course gave us not only the welcome opportunity to refresh our minds but a chance also to compare conditions of service with colleagues working in other county areas, boroughs, hospital services, etc.. The conclusion was that conditions in the W.R.C.C. service compare favourably with those of other similar areas.

The liaison with teachers continues to be good. They appear grateful for the help we can give their pupils and interested to hear how they may help in school. A good relationship between therapist and teacher and between therapist and parent helps to achieve a continuity in the treatment of the child and gives an overall coverage for dealing with the speech problem. With more therapists and consequently more time to visit schools this important liaison could be extended.

Future Needs

The W.R.C.C. realises that more therapists are needed to give a more effective coverage over its large administrative area and has, in fact, raised the establishment from thirteen to eighteen full-time posts. Unfortunately it has not been possible to fill these additional posts. Let us hope that the Manchester School will help to fill these vacancies in the near future.

Some of the rented clinic premises are not as convenient or suitable as we would wish but steps are being taken to provide some of these areas with a new clinic building. Working in these new clinics, where they exist, is a pleasure. I might add that the rented premises I use at the moment are adequate.

Routine hearing testing before beginning speech therapy treatment is not yet possible in all cases but the new portable audiometers should go a long way towards solving this problem in the near future.

The October Course demonstrated how rewarding it was to meet other therapists and have the opportunity of discussing with them various aspects of our work. It would be interesting to know if other W.R.C.C. therapists feel that meetings between them would be possible and, if so, welcome.

On the whole the service is much appreciated by both the teachers and the parents of the child as they realise that growing up with a speech defect may be a great handicap not only during school years but when starting to look for work and in future contacts with people.”

Miss M. P. Dunkley reports on work in the Harrogate Division as follows:—

“ All types of speech defects show a tendency to appear more frequently among boys than among girls, but stammering is a problem faced mainly by boys. The following figures show the ratio of boys and girls with speech defects, during the past seven years in the Harrogate Division alone:—

			Boys	Girls
1956	...	...	42	12
1957	...	...	57	11
1958	...	...	42	13
1959	...	...	51	16
1960	...	...	51	20
1961	...	...	44	14
1962	...	...	46	12

Speech defects dealt with in the School Clinic fall roughly into two groups: (a) defects of articulation, (b) stammering; the latter being a speech disorder of nervous origin. The cases of defective articulation have varied from simple dyslalia (one or two faulty sounds) to gross dyslalia, with many substitutions and elisions.

Occasionally we get a case of alalia, when there has been no development of speech at the expected age, the main causes of which are: (1) deafness, (2) mental retardation, or (3) emotional factors.

Since a child acquires his speech in the home through casual training, it is very important for him to have a good pattern; one which does not have to be relearned later, e.g., 'Baby talk'. He must also have the right stimulus; rhymes and jingles play an important part in the development of speech in the infant. Unfortunately, I am finding that these are not now used sufficiently in the home.

Although I am not qualified to state whether or not it is right for a mother to be out at work during the day, if she has children of pre-school age, I do feel most strongly that mothers who are there to help the infant up the ladder of speech development, e.g., at the babbling and repetitive stages (1-3 years) are far less likely to have children with speech defects.

Stammerers are always a challenge, but a very worthwhile one. It is most important to start treatment as early as possible in order to prevent the onset of the secondary stage. If, however, this stage has been allowed to develop, we are faced with a much more complicated pattern. The resultant feeling of insecurity and inadequacy produce excessive tension, which in some cases is painful to see.

A child with a speech defect or disorder is deprived of one of its most natural forms of self-expression. It is, therefore, easy to see how the personality of such children can be affected. The speech therapist must have a thorough understanding of human nature and a most important part of her work is to help the child to adjust his personality to a positive attitude to his difficulties and give him a desire to cure himself.

Stammerers tend to have reversions at particular stages in their school life, e.g., (a) when learning to read, (b) at the Grammar School entrance stage and (c) those who pass on to Grammar Schools, at the G.C.E. 'O' and 'A' level periods of their academic career.

The help given to the speech therapist by the health visitors is invaluable. They are in constant touch with the pre-school child. Suspected cases of hearing loss are being detected at an early age by health visitors especially trained to do this.

Home and school visiting play an important part in our work. Most teachers are only too anxious to help and are always on the alert to discover the children who require specialised help. I think that many of the minor speech defects could well be dealt with by the Infant Class teacher, if she had some special training at college to equip her for this. A short course given by an experienced speech therapist in every Teachers' Training College would be a great stride in this direction.

During my thirteen years as a speech therapist under the West Riding County Council, I have had the privilege of giving numerous talks to Parent Teachers' Associations, Young Wives Groups and similar organisations. These have given me excellent opportunities to help both the teachers and the parents, who have children with speech difficulties."

THE MALADJUSTED CHILD:

The responsibility for staffing the Child Guidance Clinics is divided between the Regional Hospital Boards and the Local Education Authority. The Hospital Boards normally supply the services of consultant psychiatrists whilst the local authority provide supporting staff and clinic premises. This pattern has been maintained in the area covered by the Sheffield Regional Hospital Board, with adequate consultant psychiatric assistance coming from Dr. Orme and Dr. Crowley who, together, give twelve sessions per week to Child Guidance Clinics in the south of the County. A modification of the arrangements has, however, been necessary in the northern part of the County for, when Dr. W. M. Burbury retired early in the year, the Leeds Board stated that they could hold out no hope of replacing her services. The situation was frankly discussed with representatives of the Leeds Board and it was finally agreed that a solution could

best be reached if the Board and the local authority could themselves, as a long term policy, try to solve their own individual problems in this field. This left the way open for the County Council to develop the plan mentioned briefly in the Report for 1961, whereby a member of the County Medical staff—Dr. Atkinson, who holds the Diploma in Psychiatric Medicine—should extend her child guidance activities by taking over the clinics left vacant by Dr. Burbury's retirement. Agreement was also reached with the Board so that consultant cover for Dr. Atkinson's clinics can be provided from the clinics where a Consultant Psychiatrist is in attendance. Arrangements are also being made for selected members of the medical staff to attend courses in child psychiatry and thus be able to filter off some of the routine cases and so relieve the pressure on the Child Guidance Clinics. It is hoped that the establishment of a child psychiatric unit at St. James's Hospital, Leeds, will ultimately provide a training ground for school medical officers.

An important aspect of child guidance work is the background report provided by the social workers and it is pleasing to report an improvement in the prospects of staffing this branch of the service. A former mental welfare officer, Mr. J. E. Skinner, is at present taking the University course leading to the Psychiatric Social Worker's Certificate and he should be available for full-time duty during 1963. Also a trainee social worker is to take up duty with a view to gaining the practical experience necessary before applying for the University course. Both these workers are hoping to qualify under the County Council's scheme for the training of Psychiatric Social Workers.

The established Child Guidance Clinics were all busy during the year and interesting reports have been submitted by the psychiatrists.

Swinton, Ecclesfield and Barnsley Clinics—Dr. Orme reports:—

“ The work at these clinics has continued in much the same pattern as in previous years. Despite an increase in the total number of attendances, the waiting list has grown towards the end of the year as more intensive casework and psychotherapy has been attempted in a number of cases. This form of treatment is, of course, very time consuming but is of value if states of chronic inadequacy can be relieved or avoided. Further developments along these lines can only be made if there is an increase in personnel; there is work waiting for additions to the staff in any discipline.

At the Swinton clinic plans have been made for greater integration of work by the Clinical Psychologist, Mr. Valentine, and Psychiatric Social Worker, Mrs. Bruce. By this measure it is hoped that greater understanding of problems at school and at home will be possible. The need is still just as great for special educational facilities—in the nature of a special class for which there is accommodation waiting at Rock House. This could be used, not only for those who show retardation due to emotional problems, but for those children (several of whom have been seen this year) who have developed severe anxiety or phobic states and who need a gradual reintroduction to working in a group. Several unusual assessment problems have also been seen and observation of their reactions on a more prolonged basis would be invaluable.

It is still very difficult to provide services for the Stocksbridge—Penistone area. The nearest clinics at Barnsley and Ecclesfield involve such time being spent in travelling that parents are often put off from attending and children lose so much time from school that secondary difficulties arise. I have held clinics in the British Hall at Stocksbridge on several occasions, but this is an irregular and unsatisfactory procedure. Initial assessments of intellectual and emotional problems have been made often by Mr. Valentine, but it is difficult to provide any treatment because of the distance.

Requests have been made for several children to go to Residential Schools. A greater variety of such schools is still very necessary, though the William Henry Smith School at Brighouse has been a great help for various boys. My frequent visits there have enabled work to be carried out on a co-operative basis using the relationships already established between the clinic staff and the family at home. In cases where there has not been good communications between other schools and the clinic, difficulties have arisen which might well have been avoided, and the final results have not been satisfactory.

Despite the dogmatic views of some psychiatrists, we have far too little scientific knowledge about normal and abnormal development, and the factors affecting learning and behaviour. Research into these problems is vital if progress is to be made and it was, therefore, a welcome move when Dr. Hilde Himmelweit of the London School of Economics asked for co-operation with a research programme into children's fears and anxieties, following up her recent research into the effect of television on children. This involved filling in extensive questionnaires by psychologist, psychiatrist and the children concerned; during the course of the programme various difficulties became apparent which underlined the need for extremely careful planning of such a project before reliable results can be obtained. It is to be hoped, however, that more work along these lines will be possible. Co-operation was continued with the research into psychotic children carried out by Dr. Creak of Great Ormond Street Hospital."

Harrogate Clinic—Dr. Gore reports:—

" Seventy-one new cases were seen during the year—this is a smaller number than in previous years, probably due to absences of staff through illness, and the lack of a psychiatric social worker. In addition Mr. Pickles was engaged in a survey of E.S.N. children in schools, which took up every Friday morning during term time.

The number of girls seen was very small, only 18 compared to 40 the previous year.

The greatest number of referrals came from Division 7 (56)—we have broken these figures down for this year and taken particular note of the actual source of the referral (e.g., a case sent to us through the Divisional Medical Officer might have been brought forward either by the Head Teacher or the parent). Looking at it in this way the sources of referral were as follows:—

Divisional Medical Officer	...	...	18
Juvenile Court and Probation Officer	...	...	3
General Practitioners	...	...	9
Parents	...	...	7
Children's Officer and Children's Homes			6
Head Teachers	...	...	10
Youth Employment Officer	...	...	2
Aural Surgeon	...	...	1
			—
			56
			—

These figures indicate the interest of both teachers and parents in the clinic and this seems to have grown over the years. We have also had, as usual, a number of cases from Children's Officers and Children's Homes. We have continued our policy of inviting to the clinic as many of the people referring cases as possible, and plan in the future to offer more opportunities for discussion to the staff of Children's Homes. We feel that perhaps our contacts with General Practitioners could be improved.

We have also studied in particular the uneventuated referrals where no regular attendance was established, and the unsatisfactory cases where, after initial attendances, the subsequent appointments were not kept. In general, it seemed from this that we were most likely to fail in cases referred from the Juvenile Courts without the real wish of the parents; and that parents who had come to the clinic because of the pressure of their own problems often did not keep up regular visits. Cases from families with multiple problems were also noticeably poor attenders. For the remainder it seemed that if an appointment had to be delayed, the moment of crisis was often passed, but in these cases we did not really know whether help was still needed.

In addition to the new cases opened in 1962, 31 were carried over from previous years. Attendances can be analysed as follows:—

Boys	Girls	
7	1	attended weekly for treatment.
12	8	attended for regular treatment.
30	12	attended for occasional visits.
—	—	
49	21	
—	—	

Also visits were made to the Wharfedale Hospital and to Bridge House School, Harewood, to see children.

Remedial Teaching

The new year began with 16 children in attendance; 11 boys and 5 girls. Of these 4 were at the secondary modern stage, and the rest at primary level and ages ranged from 7+ to 14 years.

Steady progress was made in all cases and in some quite a remarkable difference was noticeable. One Headmaster describes the change in a very deprived boy of 9 years as almost miraculous. Not only educationally but socially this boy has made fine progress though he has many physical handicaps. All the children have now broken through the reading barrier, and the Head Teachers report progress in all school subjects.

In July, 5 children were discharged and 3 new ones admitted, making 14 at the beginning of September, and since then 4 more have joined us. Except in one very disturbed case the children are now working in groups of 2 or 3, according to age and ability. Parents continue to co-operate and to appreciate the help being given, and opportunities to talk to parents and show them children's work are taken whenever possible.

Close co-operation between the members of the Child Guidance Team is maintained so that a clear all-round picture of the child's problems is always apparent.

During the year we had visits from ten Head Teachers, Youth Employment Officers, School Welfare Officer, Child Care Officers, Probation Officers, Mental Welfare Officers and, amongst our more distinguished visitors, Dr. Marjorie Wilson and Dr. Llewellyn from the Ministry of Education: Mr. Boddy, County Council Education Inspector, and Mr. Rawcliffe, Divisional Education Officer. In March Dr. Elliott paid a visit to the clinic with Dr. Marshall, who, prior to her retirement, had always been most helpful towards us.

In July Mr. Thomas, the County Council Art Advisor, visited the clinic and stimulated still further our interest in the question of art in education and clinic work, and we subsequently spent an interesting day visiting schools in the Pontefract area.

Dr. Jessop and Dr. Stoakley continued to attend the clinic until March, and during this term two students from the Institute of Education, Leeds, spent some time here. We have also had Health Visitor students in the clinic from time to time.

We feel we have an excellent liaison between the clinic team and the Divisional and Assistant County Medical Officers in all the areas we serve."

Mirfield Clinic—Dr. Leese reports:—

"The volume of work done in this clinic has increased, commensurate with the increase in time given by the staff. At the end of May, Mrs. R. Bindman was appointed as social worker for four sessions a week and from the beginning of June the psychiatrist has had an extra session, making three. But this has not diminished the waiting list, which stands at an 'all high' level of 24 on December 31st. On that day Dr. Atkinson joined us for a session a week and we hope to diminish the time lag of three to six months before a case can be started.

Of the 62 new cases seen, 40 were boys and 22 girls. Nine of the boys and 2 of the girls were E.S.N. Both of the girls were at a Secondary Modern School, but, more happily, 6 of the sub-normal boys were referred from the Infants' School. The trend to refer younger children is warmly welcomed and many of the frustrations in the children, their teachers and parents, secondary to placement in the wrong type of school can be avoided. Even better would be referrals of children age $4\frac{1}{2}$ where there is any doubt as to their intellectual endowments. Age groups were as follows:—

			<i>Infants</i>	<i>J.S.</i>	<i>Sec. Mod.</i>	<i>G.S.</i>	<i>Left</i>
Boys	...	...	11	10	16	2	1
Girls	...	...	2	1	16	1	2

Over the years the ratio of boys to girls in the clinic has been decreasing and this year's ratio of approximately 2:1 is the lowest I remember. I do not know whether patterns of behaviour are changing, or whether girls' problems are being considered more clinic-worthy, or whether there is a considerable change in the criteria for referral. Least hopeful cases are those from social problem families, and those children who have been ill-disciplined, for whatever reason, by their parents.

We had 8 cases that failed to materialise. I believe the number could be reduced if parents were clear at the time of referral what was involved, i.e., that parents and children work together for the changes that are desired. These 'uneventuated' cases belonged to no clearly defined type, but 'lapsed' ones were mostly of the social problem family variety—it is a measure of their social competence that families can manage to sustain regular clinic visits. Social problem families are best helped by people 'on the spot', e.g., Health Visitors. We are very grateful to them for all the help they have given us during the year."

Shipley Clinic—Dr. Gore reports:—

"Thirty-eight new cases were seen during 1962 (33 boys and 5 girls). Eight cases (7 boys and 1 girl) were carried over from 1962 to 1963. Fourteen children were seen weekly or fortnightly for treatment during the year and 20 children were seen less frequently for treatment or for periodic review. This is a larger number both of new cases and treatment cases than we can reasonably deal with in the time at our disposal here. The present position is that some 10 new cases are waiting to be seen for diagnosis and 5 children are waiting for regular treatment sessions, while 6 children are due to be seen for periodic review.

In addition, because of the struggle to keep up with the cases waiting we have not been able to spend as much time as is desirable with Assistant Medical Officers, Probation Officers, Head Teachers, Health Visitors, etc. It is necessary, therefore, to consider whether priority should be given to diagnosis and assessment or whether we should still continue to attempt to treat those children whose needs are greatest. Dr. Battersby is aware of the difficulties as outlined and has always been most helpful in easing our load."

The Work of the Psychologists:

Mr. Pickles undertakes the psychological work in the northern half of the County. He is a member of the Child Guidance teams at the Shipley, Mirfield, Pontefract and Harrogate Clinics and also attends at the Horsforth Audiology Clinic. Mr. Valentine is responsible for the work in the southern half of the County and he attends the Swinton, Ecclesfield, Maltby and Woodlands Child Guidance Clinics and the Doncaster Audiology Clinic. A new feature of the work undertaken by Mr. Pickles has been the group test screening procedure used on groups of backward children attending schools in the Harrogate area. This has proved to be an effective method of screening a group of children and bringing forward those likely to need an individual intelligence test by the school medical officer. This survey is described in detail by Mr. Pickles who reports as follows:—

"Work undertaken during the year can be described under the following headings:—

Child Guidance

Weekly attendances were made at child guidance clinics at Shipley, Mirfield, Pontefract and Harrogate, at the latter for two days of each week. Work in these clinics has continued on traditional lines, involving participation as a member of the clinic teams in diagnosis, liaison with schools, case conferences, remedial work and treatment of individual children, particularly at Harrogate and Shipley. There has been a need for more contact with schools than has been possible and this is a part of the work that could profitably be extended.

Some of the children referred for child guidance have been tested by the school medical officer, and there may then be indications that the psychologist need not participate so fully in the diagnostic procedure. But the majority of children have been seen by the psychologist either on initial visit to the clinic or later at the particular request of the psychiatrist. Additional tests or techniques may be required to elucidate particular problems.

The total number of children tested during the year in the clinics was 179, boys outnumbering girls by 137 to 42. They ranged in age from two to seventeen years, in tested general ability from I.Q.42 to I.Q.146. The average I.Q. was 98. Sixty-nine per cent. fell broadly within normal limits (I.Q.80 to I.Q.119), with seventeen per cent. below this range and fourteen per cent. above. This age and ability range, not to mention variety of symptoms on referral, indicates the width and interest of the work.

From year to year it has been observed that about a quarter of the children tested in the clinics have been failing in school, suffering from a degree of educational retardation that is in need of remedial attention. The figure again this year was twenty-five per cent. (37

boys, 7 girls), these being children whose reading attainment lagged not only below their chronological age but also below their tested mental age by at least 18 months or fifteen per cent. If 'under-functioning' brighter children were included, the percentage would be greater.

Handicapped Children referred for psychological examination

Requests have continued to be made for psychological examination of a number of handicapped children, mostly difficult ascertainment problems. These have been children with severe or dual, sometimes multiple, handicaps, including cerebral palsy, loss of hearing or vision, speech defects or lack of speech, and specific learning difficulties. Several of these children were seen in the clinics, but others were seen in schools, training centres or in their own homes.

The number of handicapped children seen during the year was 73. Seventeen had tested intelligence which made it seem most probable or certain that they would not be able to benefit from education in school.

Audiology Clinic

Eight attendances were made at the Horsforth Audiology Clinic. Sixteen children (13 boys, 3 girls) were given psychological tests, one was hyperactive and untestable. Various non-verbal tests were used the choice depending upon the age, condition and responsiveness of the child. All but one of the children tested were within educable range of intelligence, but five had non-verbal I.Q.'s below 70.

Survey of Educationally Sub-Normal Children in Harrogate, Knaresborough and Ripon Area

Following a meeting at the Harrogate Clinic, attended by Mr. Rawcliffe, Divisional Education Officer, Mr. Boddy, Inspector of Schools, Dr. Schofield, Dr. Marshall and the clinic team, I was invited to undertake a survey of schools in the area using a group test screening procedure. The purpose of the survey would be to screen retarded children for later individual examination by school medical officers, it being hoped that this would help to elucidate the total number of E.S.N. children in the area in need of special schooling.

Details were worked out with Mr. Rawcliffe and Dr. Hepple, and it was decided that I should first visit primary schools in Harrogate, Knaresborough and Ripon; the second phase of the survey would then cover the secondary modern schools; after which consideration would be given to visiting schools in rural areas.

Head teachers of primary schools were circularised and informed of the purpose of the survey. The selection of retarded children for group testing was made, of course, by them and there have been wide differences in numbers of children presented at different schools (45 children at one school, 5 at another, were the extremes). It was thought quite impracticable to limit the survey to particular narrow age ranges, and children in the complete primary age range from five to eleven years have been seen.

Where school conditions and the size of room available have permitted, two groups of children have been seen in the morning at most of the schools visited. Younger children have been seen before break (this being the longer period), and older children afterwards. If conditions have been good, it has occasionally been possible to see as many as ten children at once, although the necessity for close invigilation and a certain amount of individual help to some children makes this the maximum number possible.

The wide age range of the children and the need to see as many as possible in the short time available have determined the type of test to be used. It also had to be considered that these would be retarded and, not infrequently, disturbed children. The group testing needed to be non-verbal, attractive and enjoyable to them, and not too long in duration. The principal test chosen has therefore been Raven's Progressive Matrices, Sets A, Ab, B, which has an attractive coloured format, is homogeneous in type of problem, is reputed to have high 'g' content, and provides norms for the whole of the primary school age range. Very few children indeed have had any difficulty in understanding the instructions and in completing the simple score sheet, although a few have needed fairly close attention and supervision.

Using the Matrices as a non-verbal test of intellectual capacity, it has also been possible to widen the examination by administering two drawing tests, the first being a modification of the Bender Gestalt test for group use, and the second the well known Draw-a-man test which can be scored according to the system devised by F. L. Goodenough. The Bender has been used principally to scout out any outstanding strephosymbolic phenomena as well as to provide a rough guide to each child's perceptuomotor development. While the children

have been busy drawing, it has been possible also to administer individually to each child Vernon's modification of Burts' Graded Word Reading Scale, this yielding a reading age, and giving an opportunity also to make more personal observations, e.g., any speech defect, of each child. Features such as sinistrality, undue restlessness, attention seeking behaviour, apparent visual difficulties have also been noted; and further information has been given by head teachers and staff on particular children, e.g., fostering, member of problem family, particularly worrying behaviour in school, and so on.

Report sheets have been prepared after each school visit, giving details of each child, with his Matrices raw score and percentile grade, reading age, and any observations or remarks thought necessary or helpful. Copies of these have gone to head teachers and to Divisional Offices. On each report sheet, the names of those children are brought forward in whose case it has been thought particularly desirable that they should be seen for individual examination by the school medical officer. This selection has been based mainly on the possibility of the child being in need of special schooling; but some children have been so obviously disturbed emotionally that they have been mentioned as in need of examination on this count; and a few of these have subsequently been referred to the child guidance clinic by the school medical officer.

Having only Friday mornings in term time available for this work, progress has inevitably been slow. Starting in May, 8 primary schools, 4 in Harrogate, 2 in Knaresborough and 2 in Ripon, had been visited by the end of the year. It was necessary to make four visits to two schools, three visits to one, two visits to another, with single visits to the remaining schools. In all 17 visits were made. The number of children seen in groups by the end of the year was 196. Of these 62 (i.e., 32 per cent.) were suggested as being in need of individual examination. This was a very conservative selection. The children were already well selected by head teacher and staff. If intellectual limitations were not indicated by group testing, the children were failing or were giving particular concern in school for other reasons, which needed elucidating. The frustrating aspect of this work has been the inability to pursue teasing problems, obvious in so many of the children, and the necessity to restrict discussion of individual children with head teachers and staff.

The group testing has been patently enjoyed by the children taking part; and it has been fascinatingly interesting and enjoyable work for me. The survey will continue next year, when it is hoped to complete it in the primary schools in the three principal areas, and then to go on to the secondary modern schools. In them, arrangements will need to be rather different, and it will be necessary to use another test, the Standard Matrices, which takes longer to administer."

Mr. Valentine reports as follows:—

" I continued to attend the same clinics as in 1961, namely, Swinton, Ecclesfield, Maltby and Woodlands.

I also attended the Audiology Clinics, held at the Yorkshire Residential School for the Deaf, throughout the year.

The statistics given below show a slight falling off, as compared with 1961, in the number tested of children referred for full clinic investigation but an increase in all other categories.

Statistics

Children referred for full clinic investigation—number tested	133
Children seen at clinics (other than for testing)—number of interviews	102
Parent interviews at clinics... ..	97
School visits	147
Home visits	26
Children not referred for full clinic investigation—number tested:—	
Cerebral Palsy	5
Blind/Partially Sighted	6
Deaf/Hard of Hearing	26
Educational difficulties	10
Speech defects	6
Total	53

In addition, intelligence tests were given to 22 children residing at the Yorkshire Residential School for the Deaf."

Sale of Sweets in Schools:

Several attempts have been made to deal with the problem of tuck shops in schools. The County Medical Officer and the Chief Dental Officer have attended meetings of the Education Consultative Committee to lay before members the scientific basis of arguments against the sale of sweets and biscuits at school and to arouse an awareness of the dangers involved.

The case against the practice of selling sweets and biscuits in schools was presented to teachers in a special article in the Schools Bulletin.

The Committee did not take positive action to control the tuck shop activities in schools, but the position is being closely watched and some statistical information has been collated. Comparison of statistics obtained in February, 1962, and April, 1963, show a slight improvement in the situation and there has been a slight decrease in the number of schools selling sweets and chocolates and an encouraging increase in the number selling fruit or potato crisps. In one school the tuck shop was temporarily closed because of the litter problem it created and, finding that the children were then eating their dinner better, the Governors closed the tuck shop permanently.

The situation will be kept under review and it is hoped that further discussions with the Consultative Committee will result in a firm line of action.

Buzzers for Bedwetters:

The use of enuretic alarms, a warning device operated by a six-volt dry battery which can carry no shock to the patient, has produced very encouraging results. These machines are issued on loan to parents of enuretic children and Dr. Harvey, the Pædiatrician, has commented on their use as follows:—

“About two-thirds of the eight year olds seem to get prompt control with the novelty of the buzzer, but a fair proportion report lapse again after some months. My experience, and I think that of most people, seems to be that if the buzzer is going to work it will do so at once and decisively within the first fortnight; and any period of education of the bladder can be regarded as complete so far as it can go in four weeks. I would, therefore, suggest that so long as we have a waiting list we should withdraw every buzzer at the end of a month, telling the parents, without the children knowing, to keep the pads in case they might need further loan of the buzzer if relapse occurs. Thereby we would be spared the unnecessary expense of issuing new pads to the same family at any later occasion and it would mean that each buzzer could be used for about ten children per year. I appreciate there might be an occasion when an intercurrent infection might spoil the buzzer trial half way through the month, and in that case the extra week or two might be justified.”

The School Ophthalmic Service:

The provision of ophthalmologists remains the responsibility of the two Regional Hospital Boards. Some staffing difficulty was experienced in the early part of the year in the area of the Sheffield Regional Hospital Board but this has now been resolved. Any child certified as blind or partially sighted must be seen by an ophthalmologist of consultant status, otherwise the rest of the work, consisting mainly of refractions, is done by Senior Hospital Medical Officers. The clinic premises, equipment and the assistance of a nurse are all provided by the County Council. The clinics are affiliated to the various Hospital Management Committees who are financially responsible for the provision and repair of glasses.

In the case of blind and partially sighted children, it is now customary to send a copy of the consultant's report on Form B.D.8 to the general practitioner concerned.

Large numbers of children continue to attend the School Ophthalmic Clinics and the number of examinations made and the number of children for whom glasses were prescribed during 1962 is given in the following table together with similar details for previous years:—

Year	No. of children examined (including re-examinations)	No. prescribed glasses
1948	10,755	8,113
1949	12,345	7,830
1950	12,341	7,289
1951	12,514	6,970
1952	14,974	8,941
1953	17,659	9,462
1954	17,691	9,240
1955	17,265	9,926
1956	17,644	9,999
1957	17,662	9,782
1958	18,829	9,472
1959	18,784	9,411
1960	20,651	10,029
1961	20,387	9,542
1962	19,874	8,831

Medical Treatment at Clinics:

As part of the Authority's arrangements under Section 48 of the Education Act, 1944, for the medical treatment of school children, the following clinics were in operation at the 31st December, 1962:—

Type of Clinic	Number	
	Provided directly by the Authority	Under arrangements with Regional Hospital Boards
Minor Ailment and other non-specialised	184	—
Dental	51	—
Ophthalmic	—	58
Speech Therapy	65	—
Orthopædic Treatment Centres	—	15
Ultra Violet Light	43	—
Pædiatric	5	14
Chiropody	3	—
Consultant E.N.T.	—	13
Consultant Orthopædic	—	15
Consultant Dermatology	—	1
Consultant Cardiac	—	1
Orthoptic	—	1
Remedial exercises	11	—
Audiology	2	—

Consultant E.N.T. Service:

No. of sessions held 201

	Pre-school Children	School Children	Total
No. of individual children seen by consultant, including those continuing attendance from previous year	75	938	1,013
No. of above referred for operative treatment ...	56	475	531

	<i>Pre-school Children</i>	<i>School Children</i>	<i>Total</i>
No. of Children:—			
(a) who obtained operative treatment during year	23	315	338
(b) treated at school clinics	—	25	25
No. of attendances at consultant clinics ...	85	1,380	1,465
Consultant Orthopædic Service:			
<i>Consultant Clinics</i>			
No. of sessions held			159
No. of individual patients seen by consultant, including those continuing attendance from previous year	283	677	960
No. of above—			
(a) referred for operative treatment as short- stay cases only	6	49	55
(b) recommended long-stay hospital school ...	—	5	5
(c) recommended treatment by orthopædic nurse or physiotherapist—			
(i) at treatment centres	18	63	81
(ii) domiciliary	15	12	27
No. of children who obtained operative treatment during the year	5	42	47
Total number of attendances at consultant clinics	409	855	1,264
<i>Treatment Centres</i>			
No. of sessions held			1,055
Total number of patients treated (including cases continuing treatment from previous year) ...	48	445	493
Total number of attendances	663	4,728	5,391
<i>Domiciliary Treatment</i>			
Total number treated	3	—	3
Total number of visits to patients' homes ...	42	—	42
<i>Appliances</i>			
No. of appliances—			
(a) recommended	39	63	102
(b) obtained	33	60	93

Consultant Pædiatric Service:

Consultant Clinics

No. of sessions held	...	..	196			
				<i>Pre-school Children</i>	<i>School Children</i>	<i>Total</i>
No. of individual patients seen—						
(a) New cases	...	...	...	118	211	329
(b) Cases attending from previous year	...			115	384	499
Total number of attendances at clinics	...	...		305	807	1,112

The following table gives details of the various types of defect or disease for which children were referred for consultant opinion:—

<i>Defect or Disease</i>									
Central Nervous System	...	...	...	...			22	33	55
Heart and Circulatory System	...	...	...	...			20	125	145
Respiratory System, including E.N.T. Defects	...						18	89	107
Speech	...	...	...	...	...	...	8	6	14
Orthopædic	...	...	...	...	...	...	6	5	11
Skin	...	...	...	...	...	...	—	4	4
Psychological	...	...	...	...	...	...	7	8	15
Mental Defect, including Sub-normality	...	...	...	...	...	...	12	18	30
Congenital Deformities	...	...	...	...	...	...	19	6	25
Gastro-intestinal System	...	...	...	...	...	...	7	10	17
Epilepsy	...	...	...	...	...	...	7	33	40
Genito-urinary System	...	...	...	...	...	...	2	5	7
Glands	...	...	...	...	...	...	1	3	4
Nutritional	...	...	...	...	...	...	12	23	35
Developmental	...	...	...	...	...	...	48	45	93
Muscular Disease	...	...	...	...	...	...	1	4	5
Rheumatism	...	...	...	...	...	...	—	3	3
Habit Spasms	...	...	...	...	...	...	1	6	7
Incontinence	...	...	...	...	...	...	11	79	90
Migraine	...	...	...	...	...	...	1	31	32
Unclassified	...	...	...	...	...	...	30	59	89
							<hr/>	<hr/>	<hr/>
							233	595	828

Ultra Violet Light Treatment:

At the end of the year there were 43 ultra violet light clinics in operation and the following are particulars of the children treated:—

Number of sessions held	...	...	1,535			
Number of children treated during year	...	...		254	517	771
Total number of attendances	...	...		2,470	6,108	8,578

Vaccination and Immunisation:

Particulars relating to the numbers of school children immunised against diphtheria during the year and the immunisation state of the population of children of school age will be found on page 54 in the Section of the Report dealing with Epidemiology.

The scheme for the vaccination of school children against poliomyelitis continued throughout the year. Particulars of the scheme will also be found in the Epidemiological Section of the Report, on page 52.

Vaccination and immunisation programmes required a further encroachment on school time and the ready and willing co-operation of the head teachers and their staff is much appreciated.

Cleanliness:

The following figures show the number of children found to be suffering from head infestation compared with previous years:—

Year	Total number of examinations made by school nurses	Number of individual children found to be infested	Percentage of school population
1947	368,370	24,862	11·3
1948	560,631	27,361	12·4
1949	574,968	23,457	10·5
1950	523,473	20,214	8·8
1951	559,388	18,599	7·9
1952	610,201	19,772	8·1
1953	575,645	17,815	7·1
1954	549,961	13,619	5·3
1955	547,369	11,657	4·5
1956	512,868	10,379	3·9
1957	481,239	10,459	3·9
1958	523,353	9,753	3·7
1959	482,874	9,834	3·6
1960	467,937	10,341	3·9
1961	462,207	9,273	3·5
1962	421,257	8,912	3·3

Nutrition:

In 1956, the Minister of Education introduced a change in the classification of the general condition of school children. The table below is, therefore, in two parts. It is pleasing to note that continuous improvement has been maintained.

Year	Total number of pupils inspected	Classification					
		A (Good)		B (Fair)		C (Poor)	
		No.	% of Col. 2	No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1947	50,277	19,497	38·8	28,343	56·4	2,437	4·8
1948	71,858	26,077	36·3	41,876	58·3	3,905	5·4
1949	64,998	23,467	36·1	39,335	60·5	2,196	3·4
1950	61,977	26,820	43·3	33,528	54·1	1,629	2·6
1951	64,676	29,452	45·5	33,598	51·9	1,626	2·5
1952	62,156	30,506	49·1	30,635	49·3	1,015	1·6
1953	77,803	35,861	46·1	40,772	52·4	1,170	1·5
1954	79,553	40,315	50·7	38,344	48·2	894	1·1
1955	87,520	47,959	54·8	38,872	44·4	689	0·8
		Satisfactory		Unsatisfactory			
		No.	% of Col. 2	No.	% of Col. 2		
1956	89,564	87,318	97·50	2,246	2·50		
1957	83,250	81,524	97·90	1,726	2·10		
1958	84,346	83,025	98·43	1,321	1·57		
1959	88,398	87,484	98·97	914	1·03		
1960	83,630	82,892	99·12	738	0·88		
1961	82,938	82,343	99·28	595	0·72		
1962	82,395	81,950	99·46	445	0·54		

SCHOOL MEALS:

The number of meals provided to school children daily according to a check made in October, 1962, was 143,907 compared with 142,662 in October, 1961. This represents 58·59 per cent. of children on the registers.

Medical Examination of Entrants to Training Colleges:

In connection with their applications for entry to Training Colleges, 1,320 students were medically examined during the year by the School Medical Officers, compared with 1,215 for the year 1961 and 1,206 for the year 1960.

Children and Young Persons Act, 1933, Employment of Children:

Under the Authority's bye-laws relating to the employment of children, 1,561 children were examined during the year by the School Medical Officers to determine their fitness for employment. The figure includes children taking part in entertainments. Five cases were found unfit.

Youth Employment Service:

The School Health Service maintains close liaison with the Youth Employment Service. The Youth Employment Officers visit schools to discuss with teachers and parents the type and suitability of occupations of those children about to leave school.

Prior to this the leavers will have received their final routine medical inspection and the School Medical Officer will have informed the Youth Employment Officer of those children who are handicapped in such a way that their choice of employment is limited.

After the handicapped child enters employment, the services of the School Medical Officer are still available to advise the Youth Employment Officer if any difficulty is encountered either regarding the actual occupation or from the point of view of the employer.

Protection of School Children Against Tuberculosis:

TUBERCULIN TESTING OF ENTRANTS:

Routine tuberculin testing of school entrants was undertaken in six Divisions. A total of 6,414 children were tested of whom 14 gave a positive result. These children were followed up through the Chest Physicians and X-rayed where considered necessary. Investigations were also made into the home contacts. Two new cases of tuberculosis were discovered as a result of these tests, one in an adult and one in a child; both were relatives of a positive reactor.

Particulars of the Authority's scheme for the B.C.G. vaccination of school children and of the number of children dealt with during 1962 will be found in the County Medical Officer's Report.

THE SCHOOL DENTAL SERVICE

The following is the Report of the Principal School Dental Officer, Dr. Davies.

The year 1962 has been a most successful one for the School Dental Service. Considerable advances have been made in the provision of premises and equipment carrying the service into more and more areas hitherto insufficiently provided for; and most satisfactory of all there has been a notable increase in full-time staff with consequent improvement in the service.

Staff:

At the end of the year the full-time dental staff consisted of one Principal School Dental Officer, one Orthodontic Consultant, five Senior Dental Officers and forty-nine Dental Officers, representing an increase over the previous year of one Senior Dental Officer and twelve Dental Officers. The number of part-time Dental Officers was reduced from twenty-six to sixteen, the sessions worked by those remaining being the equivalent of 4.7 full-time officers, thirteen vacancies remained unfilled.

Most of the recruits were newly qualified Dental Surgeons but four had left general practice and two the hospital service in order to join the County service. We were particularly pleased to welcome as Senior Dental Officer Mr. Hollings, formerly senior lecturer in conservative dentistry at Leeds University and Honorary Consultant to the United Leeds Hospitals.

On the 31st December, Mr. Levinson retired from the post of School Dental Officer which he had occupied since 1940. Previously in general practice in Hull Mr. Levinson moved to the West Riding when his premises were destroyed by enemy action. He is the last School Dental Officer in the Riding to have worked full-time with portable equipment which he continued to do until the Horsforth Clinic was opened in 1960.

Since the inauguration of the National Health Service in 1948, the attraction of general practice has been such that very few newly qualified Dental Surgeons have entered the public service as full-time officers. Events in 1962 suggest that young dentists are now seriously considering the public service as an acceptable

alternative, but the position is far from stable, for at the end of the year two of these young recruits, each with less than twelve months' service, had handed in their resignations in order to take up assistantships in general practice.

Of the sixty students completing the first two year course for dental auxiliaries at New Cross General Hospital in London, fifty passed the qualifying examination and were admitted to the register maintained by the General Dental Council. Although the girls had been selected for admission to the school partly on a geographical basis in an attempt to ensure reasonable dispersal throughout the country on employment only one candidate expressed a wish to work in the Riding and she was a native of Surrey. She took up her employment in the County service on the 1st October, and after an introductory period whole-time at the Central Dental Clinic she subsequently worked two days each week at the Central Clinic and three days at the Hemsworth Clinic. A dental auxiliary is permitted to extract temporary teeth and to do simple fillings in all teeth, under direction.

At the end of the year a special report on her work comprising of the observations of the supervising Dental Officers, Principal Dental Officer and the Principal Medical Officer was submitted to the General Dental Council together with a statistical analysis of the work done. This report was to the effect that her work was of a high standard and satisfactory in quantity. There had been no difficulties of acceptance of the auxiliary by dental officers or others and no untoward incidents had occurred.

The only criticism voiced was the undue interruption at times of the supervising Dental Officers' routine in order to prescribe treatment to be done by the auxiliary and to inspect the treatment on completion. It was thought that administrative arrangement could be made in the future to minimise this interference.

The clinical work carried out by the dental auxiliary from the 1st October to 31st December was as follows:—

Number of children treated...	...	...	...	...	...	...	79
Number of fillings in deciduous teeth	...	...	...	...	...	...	176
Number of fillings in permanent teeth	...	...	...	...	...	...	356
Total fillings	...	...	...	...	...	...	532
Number of deciduous teeth extracted	...	...	...	...	...	...	20
Number of children given prophylactic treatment	...	...	...	...	...	...	36

Premises and Equipment:

New dual surgery purpose built clinics were opened during the year at Worsbrough, Thurnscoe, Goldthorpe, Dinnington and Selby. All were staffed with full-time officers with the exception of Goldthorpe where the Dental Officer centred on Wath was in attendance for two days each week. A second surgery was provided in the clinic at Shipley and staffed with a full-time officer. Additional equipment was provided for the anæsthetic and orthodontic surgeries at the Central Clinic to enable both surgeries to be in full-time use as well as the two general purpose surgeries.

Eight additional surgeries were provided with the ultra high speed apparatus including the mobile surgeries. All three mobile clinics were in operation throughout the year.

A start was made during the year in covering the surgery floors of former decontamination centres with vinyl tiles.

There has been an increasing tendency on the part of Dental Officers acting as anaesthetists to employ the new anaesthetic Halothane rather than Vinesthene as an adjuvant to nitrous oxide gas, and a number of vapourisers for attachment to anaesthetic machines has been provided.

The dental laboratory has obtained further needed equipment. An electronic welder has been provided for the construction of the more intricate orthodontic appliances and suitable apparatus including a high temperature furnace has been obtained for the manufacture of porcelain inlays and jacket crowns.

Inspection and Treatment:

It is to be noted that there is a difference in two items of the appended statistical table compared with that of previous years. The item showing the number of attendances made by pupils for treatment no longer includes those made for orthodontic purposes, which are now shown separately and there is an additional item showing the number of half-days devoted to orthodontics. Apart from the Orthodontic Consultant only three officers devote half-days exclusively to the practice of orthodontics so that the figure shown under this item has had to be estimated. It will be seen that, taken as a whole, dental officers appear to be devoting about one tenth of their clinical time to orthodontic treatment.

The total number of half-days worked in the service was an increase of 2,703 over 1961, equivalent to an increase throughout the year of approximately six Dental Officers, and this improvement in the staffing position is represented in all the statistics. Twenty-two thousand, six hundred and ninety-seven more children were inspected in school than last year and 16,055 more attendances were made at the clinics. For the second year in succession there was a large increase in the number of fillings, 21,739 more than in 1961 (31,881 more than in 1960), although this year the number of extractions did not drop but increased by 6,145.

Two hundred and fifty-eight more children than in 1961 were provided with orthodontic treatment, all of them being treated by means of appliances.

Provision of advanced conservative work consisting of gold and porcelain restorations was commenced during the year on the appointment of Mr. Hollings to the senior staff. He spent two days weekly in the Central Clinic to which patients requiring this type of work were referred. Towards the end of the year he also attended the Harrogate Clinic one day each fortnight for the same purpose. Children attending these clinics are often those with front teeth broken accidentally and in these cases a crown or bridge restoration obviates the need of a denture which would otherwise have to be worn throughout life.

Dental Health Education:

It was decided early in the year to make an attempt to systematise the dental health education in the Riding and to utilise dental hygienists for this purpose.

For some years the two posts of dental hygienists had been allowed to remain vacant as experience had shown that there was great administrative difficulty in providing hygienists with sufficient operative work to keep them fully employed.

Their clinical work consists in the scaling and polishing of the teeth and the application of medicaments. This work is required much more frequently by adults than by children but hygienists however are also trained in dental health education and recently more attention has been given to that aspect of the Local Authorities' functions which consists of the promotion of dental health and the prevention of dental disease.

For this reason the time was thought opportune to fill the two vacancies by appointing dental hygienists specially interested in dental health education and to employ them full-time on these educational duties. Miss Vince was appointed on the 1st March, 1962, and Miss Prior on the 10th September, 1962.

A report on their work, which has been carried out in co-operation with the Deputy County Nursing Officer who is responsible for health education throughout the County, is included below:—

Number of schools visited	...	...	...	...	...	...	193
Number of talks given	...	...	...	...	...	...	532
Number of sound film showings (10-9-62—31-12-62 only)	...	...	...	...	...	...	60
Number of film strip showings	...	...	...	...	...	...	159
Sound film audiences	...	...	...	...	...	...	5,150
Film strip audiences	...	...	...	...	...	...	5,990
Talk audiences	...	...	...	...	...	...	27,262
Total audiences	...	...	...	...	...	...	30,092
Size of audiences	...	...	...	...	...	...	18-435
Age of audiences	...	...	...	...	...	3 years-18 years	

General Remarks:

A very successful staff meeting was held at the Central Clinic on the 1st June. The meeting, which lasted the full day, consisted of papers read by the senior clinical and administrative staff followed by general discussions.

An orthodontic study group met six times during the year and arranged table demonstrations which were exhibited at the British Dental Association Annual Conference at Nottingham and at the Orthodontic Society at Sheffield.

A number of one-day courses were arranged by the senior staff. Miss Sclare continued to give instruction in Orthodontics to Dental Officers who attended her clinics at Wakefield. Mr. Hollings gave tuition on alternate Wednesdays to a succession of Dental Officers anxious to take advantage of the new facilities available for extending the range of treatment provided, and the Chief Dental Officer provided one-day seminars for inexperienced new recruits to the service to familiarise them with the distinguishing characteristics of public health dentistry.

In August a circular was issued jointly by the Ministries of Education and Health on the Local Authority Dental Services, asking Local Authorities to review all aspects of their Dental Services and to give particular attention to dental manpower and the promotion of dental health.

A number of suggestions were made for attracting and retaining staff all of which have already been used in this Authority's service. One thing, however, which will require close attention in the near future is the number of senior posts in relation to the needs of the work and to individual officer's prospects of advancement.

The Ministries consider that Local Authorities can do much to improve dental health by vigorous and sustained campaigns of dental health education. What has been done in this field in the West Riding has already been outlined but at the end of the year a long-awaited means of promoting dental health appeared to be within sight. On the 10th December, the Minister of Health stated that he considered water undertakers would be within their rights in fluoridating drinking water. He said he looked forward to approving arrangements made by the Local Health Authority to this end.

In July was published the Report on "Conduct of Fluoridation Studies in the United Kingdom and Results achieved after five years" which showed that the number of decaying teeth in children was reduced in those areas where drinking water had been fluoridated to a level of 1 ppm. Evidence that dental decay is reduced when fluoride is in the water supply has long been universally admitted and now, after more than twenty years' intensive research, every major health organisation is convinced that fluoridated drinking water has no detrimental effect whatsoever on general health. Water supplies in the West Riding are mostly deficient in this beneficial trace element. By adjusting the level to 1 ppm. there is available a cheap, reliable and safe method of reducing by half the decayed teeth of school children in one decade. It is hoped that next year will see measures taken to give the children the benefit of this 20th century discovery.

Orthodontic Report:

The following is a Report by the Consultant Orthodontist, Miss Sclare:—

The popularity of the Orthodontic Service with patients and dental officers continues. It is interesting to note that several of the dental officers who have recently joined the staff have already treated simple cases and are now asking for guidance in the treatment of more complicated ones. Every encouragement will be given to the dental officer who shows an aptitude for this specialist branch of dentistry. Once he has organised the routine treatment of the school children in his area and has got this under control he will be given the opportunity to attend the Central Orthodontic Clinic at Wakefield for instruction in diagnosis and more advanced techniques.

Orthodontic treatment without the benefits of routine conservative treatment is a waste of time. It is of little use correcting irregularities in the position of the teeth if they are soon to be lost owing to neglected caries. It is important that orthodontics and conservative treatment should be integrated.

It will be noted that the orthodontic returns show a drop in the number of fixed appliances fitted in 1962, 262 in 1961 and 154 in 1962. The use of fixed appliances requires a high degree of skill and knowledge and at present only 8 dental officers are using this type of appliance. There are, however, certain types of malocclusion that are best treated and in some cases can only be treated by this method.

Dental officers not skilled in this technique are instructed to send patients requiring fixed appliances to the Central Orthodontic Clinic for consultation and treatment. Where possible, after consultation, the cases are transferred to their nearest clinic where treatment is available.

Another reason for the fall in the number of fixed appliances is due to the improved design of removable appliances which makes it possible to treat more types of cases by this method. The use of removable appliances also means a

saving in chair side time, as these are made in the Dental Laboratory while fixed appliances involve a considerable amount of work at the chair side. It also means that more dental officers under the guidance of the Orthodontic Consultant are able to treat more cases. This is an advantage to the patient as it saves the time and money necessarily expended on journeys to and from clinics outside the area in which he lives. I would like to add, however, that, where patients and parents are genuinely interested in orthodontic treatment, travelling long distances presents no problems. In some cases the journeys to the clinic involve several hours but these patients come in every kind of weather uncomplainingly, so appreciative are they of the treatment given. This appreciation and the personality changes that take place in our patients by providing them with a pleasing facial appearance are the orthodontist's greatest reward.

We again gave a demonstration at the Annual Meeting of the British Dental Association held in Nottingham. We are now endeavouring to make a permanent collection of models, for demonstration purposes, of cases of malocclusion showing the condition of the teeth before and after treatment and of the appliances used, which will illustrate the work of the Orthodontic Service in the West Riding. We are indebted to the staff of the Dental Laboratory for the excellent acrylic models they have made for us. Once again I would like to put on record my thanks to them, not only for these models, but for their interest and co-operation in the designing and making of all our appliances.

Dental Inspection and Treatment Carried Out during the Year:

Number of Pupils inspected by Authority's Dental Officers—

At Periodic Inspections	...	...	...	...	...	...	...	137,474
As Specials	...	...	...	...	...	...	...	7,235
Total								144,709

Number found to require treatment	...	...	...	...	...	...	...	103,029
Number offered treatment	...	...	...	...	...	...	...	84,142
Number actually treated	...	...	...	...	...	...	...	52,526
Number of attendances made by pupils for treatment	...	...	...	...	...	...	...	133,407

Half-days devoted to—

Periodic School Inspection	...	...	...	...	...	...	...	1,196
Treatment	...	...	...	...	...	...	...	19,010
Total								20,206

Fillings—

Permanent	...	...	...	...	...	...	...	123,093
Temporary	...	...	...	...	...	...	...	7,728
Total								130,821

Number of teeth filled—

Permanent	...	...	...	...	...	...	...	104,399
Temporary	...	...	...	...	...	...	...	6,936
Total								111,335

Extractions—									18,505
Permanent	...	...	...	...	...	...	...	...	51,891
Temporary	...	...	...	...	...	...	...	...	70,396
Total									70,396
Administration of General Anæsthetics for Extraction									20,966
Number of pupils supplied with artificial teeth									917
Other operations—									32,011
Permanent teeth	...	...	...	...	...	...	...	...	2,792
Temporary teeth	...	...	...	...	...	...	...	...	34,803
Total									34,803
Orthodontics:—									14,854
Number of attendances made by pupils for orthodontic treatment									2,546
Half-days devoted to orthodontic treatment									1,353
Cases commenced during the year									2,332
Cases brought forward from the previous year									903
Cases completed during the year									154
Cases discontinued during the year									3,685
Number of pupils treated by means of appliances									2,224
Number of removable appliances fitted									154
Number of fixed appliances fitted									

KEIGHLEY EXCEPTED DISTRICT

The following report on the year's work is submitted by Dr. McDonagh, the Borough School Medical Officer to the Keighley Excepted District:—

Introduction:

This report is compiled in accordance with arrangements made by the County Council of the West Riding of Yorkshire as to the School Health Service in the Borough of Keighley and details the work carried out during the year under review.

The selective scheme described in previous reports was continued unchanged throughout the year. Examination of the comparative table of inspections in the body of the report will reveal that more than 50 per cent. of the school population of 9,420 were seen by the School Medical Officers. Of these a number of children were examined more than once as will be seen from the fact that 1,860 re-inspections were carried out during the year. It is felt that these figures go far towards disposing of objections to the dropping of the routine inspections on the grounds that many children would fail to be examined by the school medical officers. It will also be noted that, along with a diminishing amount of physical illness discovered, went an inordinate increase in the number of behaviour or psychiatric disorders. It is felt that, by releasing the doctors from routine medical inspections which in the main reveal abnormal physical conditions and allowing them to concentrate more on behaviour problems, we are more properly utilising their special qualifications. In the almost complete absence of satisfactory child psychiatric facilities the school medical officers have carried out a certain amount of supportive treatment and have generally shown great interest and skill in the work. It would seem that this area suffers particularly from a shortage of child psychiatrists and it is hoped that every effort will be made to improve the service in the very near future. Closely allied to the shortage of child psychiatrists goes the need for more training and experience for school medical officers and health visitors to enable them to handle these cases skilfully. This would require attendance at specially designed courses for these officers.

Details of the audiometric survey show that reference of children "at risk" was probably a more worthwhile means of finding defects than the ordinary routine testing of the six and seven year olds. Nevertheless it is intended to continue with both methods for a further period to see which is, in fact, the more effective. The health visitors have been assisted in their routine work by trained nurses and have thus had more time to concentrate their attention on health education. It is pleasing to report that in many of the schools regular instruction is being given to selected groups of children. The subjects chosen were decided after discussions with school teachers and included care of the teeth, personal hygiene, diet, food values, etc. In these sessions the health visitor does not give "talks" but attempts to stimulate learning by encouraging the children to take an active part in their subject. This method of teaching by class participation cannot easily be applied for an isolated teaching session but must be part of a routine scheme. During the year, 90 per cent. of all secondary school children and a good proportion of 11 year olds received instruction in the facts relating to the effects of smoking on health. In most instances this took the form of a film followed by discussion and questions.

As in previous reports we would like to thank especially the school teachers for their close collaboration and assistance in carrying out the selective scheme. It is obvious that this scheme cannot succeed without close co-operation between all concerned.

Medical Inspection of School Children:

The number of pupils on the registers at the end of the year is shown below together with the figures for the previous year:—

				1962	1961
Nursery	...	...	...	40	40
Primary	...	...	...	4,772	4,723
Secondary Modern	...	...	...	2,221	2,332
Secondary Grammar	...	...	...	1,448	1,507
Secondary Technical	...	...	...	479	469
Special Schools	...	...	...	89	75

TABLE I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS)

A. Periodic Medical Inspections

Age groups inspected (by year of birth), number of pupils examined together with details of the physical conditions of the pupils inspected.

Age Groups inspected (By year of birth)	Number of pupils inspected	Physical Condition of Pupils Inspected			
		Satisfactory		Unsatisfactory	
		No.	Percent. of Col. 2	No.	Percent. of Col. 2
1958 and later	55	55	100·0	—	—
1957	557	557	100·0	—	—
1956	283	283	100·0	—	—
1955	33	33	100·0	—	—
1954	—	—	—	—	—
1953	—	—	—	—	—
1952	11	11	100·0	—	—
1951	5	5	100·0	—	—
1950	10	10	100·0	—	—
1949	12	12	100·0	—	—
1948	399	398	99·7	1	0·3
1947 and earlier	437	437	100·0	—	—
Totals	1,802	1,801	99·9	1	0·1

B. Pupils Found to Require Treatment

Number of individual pupils found at Periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Age Groups Inspected (By year of birth)	For defective vision (excluding squint)	For any of the other conditions recorded in Table III	Total Individual Pupils
1958 and later	—	7	7
1957	—	49	49
1956	2	28	29
1955	2	2	4
1954	—	—	—
1953	—	—	—
1952	2	—	2
1951	—	—	—
1950	1	1	2
1949	3	1	3
1948	28	19	44
1947 and earlier	34	22	52
Total	72	129	192

C. Other Inspections

Number of special inspections other than periodic medical inspections and re-inspections which is an inspection subsequent to a periodic medical inspection or special inspection.

Number of Special Inspections ...	3,216
Number of Re-Inspections ...	1,860
Total ...	<u>5,076</u>

Comparative Table of Inspections carried out from 1958—1962.

Year	Periodic	Specials	Re-Inspections
1958	3,000	2,898	1,356
1959	2,812	2,636	1,522
1960	1,471	3,018	1,532
1961	1,641	2,865	1,464
1962	1,802	3,216	1,860

TABLE II
INFESTATION WITH VERMIN

(i)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	13,475
(ii)	Total number of individual pupils found to be infested ...	329
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944) ...	3
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944) ...	1

TABLE III
DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED
31ST DECEMBER, 1962

All defects noted at medical inspection as requiring treatment are included in the following tables, whether or not this treatment was begun before the date of the inspection.

A. Periodic Inspections

Defect Code No.	Defect or Disease	Periodic Inspections							
		Entrants		Leavers		Others		Total	
		(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)
4	Skin	3	9	9	12	—	1	12	22
5	Eyes—a. Vision	2	17	62	149	8	8	72	174
	b. Squint	15	26	2	8	—	1	17	35
	c. Other	1	10	1	4	—	—	2	14
6	Ears—a. Hearing	2	18	1	5	—	—	3	23
	b. Otitis Media	—	16	1	2	—	—	1	18
	c. Other	4	6	5	2	—	—	9	8
7	Nose and Throat	8	123	4	22	—	2	12	147
8	Speech	25	18	4	4	1	—	30	22
9	Lymphatic Glands	—	10	—	1	—	—	—	11
10	Heart	—	10	1	14	—	—	1	24
11	Lungs	7	57	2	17	—	—	9	74
12	Developmental—a. Hernia	—	2	—	—	—	—	—	2
	b. Other	1	27	—	—	—	2	1	29
13	Orthopædic—a. Posture	4	2	5	2	—	1	9	5
	b. Feet	14	18	3	10	—	2	17	30
	c. Other	5	13	2	19	—	—	7	32
14	Nervous System—a. Epilepsy	—	2	—	1	—	—	—	3
	b. Other	1	16	—	2	—	—	1	18
15	Psychological—a. Development	1	8	—	3	—	—	1	11
	b. Stability	—	60	—	15	—	2	—	77
16	Abdomen	—	6	—	2	—	—	—	8
17	Other	3	8	5	9	3	1	11	18

B. Special Inspections

Defect Code No.	Defect or Disease	Special Inspections	
		Requiring Treatment	Requiring Observation
4	Skin	86	35
5	Eyes—a. Vision	344	873
	b. Squint	29	105
	c. Other	24	23
6	Ears—a. Hearing	28	97
	b. Otitis Media	18	50
	c. Other	31	12
7	Nose and Throat	53	193
8	Speech	119	79
9	Lymphatic Glands	7	11
10	Heart	7	60
11	Lungs	41	154
12	Developmental—a. Hernia	—	3
	b. Other	6	30
13	Orthopædic—a. Posture	22	16
	b. Feet	18	47
	c. Other	36	37
14	Nervous System—a. Epilepsy	10	13
	b. Other	6	25
15	Psychological— a. Development	147	76
	b. Stability	44	171
16	Abdomen	5	40
17	Other	72	69

TABLE IV
TREATMENT OF PUPILS

Notes

The figures given under this heading include:—

- (i) cases treated or under treatment by members of the Authority's own staff;
- (ii) cases treated or under treatment in the Authority's school clinics under National Health Service arrangements with the Regional Hospital Board; and
- (iii) cases known to the Authority to have been treated or under treatment elsewhere.

A. Eye Diseases. Defective Vision and Squint

	Number of cases known to have been dealt with	
	1962	1961
External and other, excluding errors of refraction and squint ...	48	100
Errors of refraction (including squint)	247	176
Total	295	276
Number of pupils for whom spectacles were prescribed	232	130

During the year 229 cases of defective vision and 18 cases of squint were examined by the visiting Ophthalmic Surgeon, a further 48 cases suffering from other conditions of the eye such as Blepharitis and Conjunctivitis were treated at the Minor Ailments Clinic.

After testing it was found that in 43 cases existing spectacles were considered to be satisfactory, in 105 cases spectacles were not found to be necessary and 19 cases were referred to the Bradford Eye and Ear Hospital.

The number of repairs to and replacements of spectacles amounted to 243.

B. Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been dealt with	
	1962	1961
Received operative treatment:		
(a) for diseases of the ear	3	—
(b) for adenoids and chronic tonsillitis	212	123
(c) for other nose and throat conditions	21	12
Received other forms of treatment	62	77
Total	298	212
Total number of pupils in schools who are known to have been provided with hearing aids		
(a) in 1962	4	
(b) in previous years	4	

Audiometric Survey:

The audiometric survey of six to seven year old children was continued during the year and in addition children “at risk” were also referred for investigation. The “ at risk ” category includes children with a history of prematurity, speech defect, middle ear disease, speech retardation, education retardation, etc. The table set out below shows the figures obtained from the tests with the causes referred for investigation. At the present time we are of the opinion that the referral of children “at risk” is showing a greater capacity for case finding than the routine testing but it is intended to continue with both methods for a further period to see which is the more effective. As previously all cases which were found to have defects were first examined thoroughly at the school clinic and only if found defective after this further examination were they referred to the otologist.

Children Tested by Pure-Tone Audiometry

	No	Referral for	Already
	Number appreciable	investi-	attending
	Tested hearing loss	gation	Otologist
“ At risk ” categories—Children with history of:—			
Prematurity	—	—	—
Congenital defects... ..	2	2	—
Perinatal abnormalities, e.g., asphyxia, kernicterus, known rhesus incompatibility	—	—	—
Cerebral palsy	1	1	—
Middle-ear disease	30	19	10
Meningitis or encephalitis	1	—	1
Streptomycin treatment	—	—	—
Speech retardation or defect	27	25	2
Educational retardation	19	17	2
Maternal rubella (in first three months of pregnancy)	—	—	—
Deafness in the family	1	—	1
Routine test on children in 6/7 year age group	537	530	4
Referred for possible hearing loss...	28	21	6
	646	615	26
			5

C. *Orthopædic and Postural Defects*

	Number of cases known to have been treated	
	1962	1961
(a) Pupils treated at clinics or out-patient departments	176	210
(b) Pupils treated at school for postural defects	—	—
Total	176	210

Consultant Clinic:

Number of sessions held	9
--------------------------------	---

	<i>Pre-school School Children Children</i>	
Number of individual patients seen by consultant, including those continuing attendance from previous year ...	3	13
Number of above—		
(a) referred for operative treatment as short-stay cases only	—	—
(b) recommended long-stay hospital school	—	—
(c) recommended treatment by orthopaedic nurse or physiotherapist—		
(i) at treatment centres	—	—
(ii) domiciliary	—	—
Number of children who obtained operative treatment	—	—
Total number of attendances at consultant clinic	3	29
<i>Treatment Centres:</i>		
Number of sessions held 500		
Total number of patients treated (including cases continuing treatment from previous year)	4	176
Total number of attendances	40	1,993
<i>Domiciliary Treatment:</i>		
Total number treated	—	—
Total number of visits to patients' homes	—	—
<i>Appliances:</i>		
Number of appliances—(a) recommended	—	—
(b) obtained	—	—
<i>Physiotherapy:</i>		

The following shows details of the work undertaken by the Authority's Physiotherapist.

<i>School Children</i>							<i>No. of Cases</i>	<i>Attendances</i>
Asthma	...	...	...	...	...	...	11	137
Breathing	...	...	...	...	...	...	49	541
Bronchitis	...	...	...	...	...	...	4	31
Cerebral Palsy	...	...	...	...	...	...	1	4
General Exercises	...	...	...	...	...	...	1	17
Kyphosis	...	...	...	...	...	...	—	—
Remedial Exercises	...	...	...	...	...	...	9	89
Anterior Poliomyelitis	...	...	...	...	...	...	1	20
Flat feet	...	...	...	...	...	...	48	546
Hemiplegia	...	...	...	...	...	...	—	—
Lordosis back	...	...	...	...	...	...	—	—
Poor chest development	...	...	...	...	...	...	6	36
Posture	...	...	...	...	...	...	29	314
Postural drainage	...	...	...	...	...	...	5	72
Round shoulders	...	...	...	...	...	...	6	67
Scoliosis	...	...	...	...	...	...	3	18
Spastics	...	...	...	...	...	...	3	107
Stoop	...	...	...	...	...	...	—	—
<i>Pre-school Children</i>								
Flat feet	...	...	...	...	...	...	4	40

D. Diseases of the Skin (excluding uncleanness for which see Table II):

									Number of cases known to have have been treated	
									1962	1961
Ringworm—(a)	Scalp	...	...	...	...	...	...	...	—	—
	(b) Body	...	...	...	...	...	...	...	1	7
Scabies ...	...	...	...	...	...	...	...	...	13	18
Impetigo	...	...	...	...	...	...	...	...	30	78
Other skin diseases	...	...	...	...	...	...	...	...	40	109
Total ...									84	212

As in previous years a large part of the work carried out at the minor ailments clinic consisted of the treatment of cuts, abrasions, septic fingers and skin diseases.

E. Child Guidance Treatment:

The nearest Child Psychiatric Clinic is at Shipley but this only consists of one session per week to cater for Keighley and the Shipley Divisional Health area. Details are given below of pupils who were referred to the School Medical Officers for examination and approximately 116 sessions were spent on these children. Naturally further time was spent in writing reports, case conferences, etc., which have not been included in the assessment. Many other cases of a doubtful psychiatric nature, for example, nocturnal enuresis, were dealt with at routine consultant clinics and school medical sessions. During the year more cases of maladjustment were referred by the teachers and others for examination than in previous years. Ninety-four new cases were examined at the clinic and 60 old cases carried over from the previous year. The practice is for the School Medical Officer and Health Visitor to examine the case from its clinical and social aspects and, if the case is suitable, treatment is carried out at the clinic. In view of the shortage of expert psychiatric assistance only the severely disturbed were referred for psychiatric opinion. Of the 94 new cases seven were referred for psychiatric opinion and of the 60 old cases four.

The increase in the number of behaviour problems during the past few years has been remarkable and is extremely worrying. Investigation of these cases in the great majority of instances showed that the behaviour symptoms in the child almost invariably arose from an unsettled domestic background where one of the parents had left home or frequently leaves home for varying periods. This increase in family break-up is causing concern to all, especially as many of the behaviour problems in children from these unsettled homes cause them eventually to appear in the Juvenile Court. It is interesting to note that in the cases where there is family break-up many of the parents themselves are the children of previously broken homes. It is very difficult to know how to break this vicious circle; more constructive preventive work is undoubtedly required. It is hoped that the new Children and Young Persons Act will give power to carry out this preventive work.

Apart, however, from family break-up we must observe that in many instances it would seem that the educational methods of selection were not altogether free from blame. Although there has been much talk in the past about the disadvantages of early and rigid selection it is only now that evidence of the harm done is beginning to come to light. This affects not only those who fail the test, but also in some cases imposes too great a strain on the child in the selected school.

New cases seen in 1962: 94

Time approx. 83 sessions

<i>Referred by</i>		<i>Reason for Referral</i>		<i>Recommendation</i>	
Teachers	41	Behaviour Disorder	45	Treatment at School Clinic	43
School Medical Officer	15	Retarded scholastic attainment	37	Treatment at School Clinic and Special School	6
Parents	12	Physical Defect	6	Observation in Ordinary School	25
Probation Officer	6	Physical Defect and retarded	6	Special School	19
Magistrates	3			Pædiatrician	1
General Practitioners	4				
Pædiatrician	8				
Orthopædic Surgeon	1				
W.R. Chief Education Officer	1				
Borough Education Officer	1				
Mental Welfare Officer	1				
Speech Therapist	1				
Referred for Psychiatric opinion: 7					
Transfer from Grammar School to Secondary School: 1					

Old cases seen in 1962: 60

Time approx. 33 sessions

<i>Referred by</i>		<i>Reason for Referral</i>		<i>Recommendation</i>	
Teachers	19	Behaviour Disorder	21	Treatment at School Clinic	14
School Medical Officer	29	Retarded scholastic attainment	28		
Parents	1			Treatment at School Clinic and Special School	5
Probation Officers	2	Physical Defect	11	Observation in ordinary school	8
Magistrates	2				
General Practitioner	1			Special School	18
Pædiatrician	3			Home Tuition	1
Borough Education Officer	1			School Clinic and Home Tuition	1
Health Visitor	1				
Ophthalmic Surgeon	1			Observation at Home	1
				Unsuitable for Education	3
				Care and Guidance	8
				Care and Guidance and School Clinic	1

Referred for Psychiatric opinion: 4

Reversal of custody: 1

F. Speech Therapy:

*Number of cases known
to have been treated*

1962	1961
186	97

Pupils treated by speech therapist

Details of the work carried out by the Authority's Speech Therapist are set out below:—

Total number of sessions held	...	...	...	...	...	...	461
(a) Number of new cases treated	...	...	...	...	...	...	133
(b) Number of cases already attending for treatment from previous year	...	...	...	...	...	...	53
(c) Total number of cases treated (a + b)	...	...	...	...	...	...	186
Number of cases awaiting treatment at end of year	...	...	...	...	...	...	63
Number of visits made to schools	...	...	...	...	...	...	8
Number of home visits	...	...	...	...	...	...	—

Analysis of Cases Treated:

								Boys	Girls
Stammering	...	...	...	...	...	...	...	19	4
Defects of articulation—									
(a) Dyslalia	...	...	...	...	...	...	...	69	33
(b) Sigmatism	...	...	...	...	...	...	...	5	1
(c) Rhinolalia, due to (i) Cleft palate	...	...	...	...	...	...	...	1	—
(ii) Nasal obstruction	...	...	...	...	...	...	...	1	2
(d) Dysarthria	...	...	...	...	...	...	...	2	1
Aphasia	...	...	...	...	...	...	...	—	—
Defective speech due to (i) Educational sub-normality	...	...	...	...	...	...	...	31	13
(ii) Deafness	...	...	...	...	...	...	...	2	2
Retarded speech development	...	...	...	...	...	...	...	—	—
Dysphonia	...	...	...	...	...	...	...	—	—
Other defects—Dysarthria	...	...	...	...	...	...	...	—	—

Analysis of Cases Discharged:

								Boys	Girls
Number of children discharged	...	...	...	...	...	...	...	48	17
Speech normal	...	...	...	...	...	...	...	30	10
Speech improved	...	...	...	...	...	...	...	2	5
Unsuitable for treatment	...	...	...	...	...	...	...	—	—
Non-co-operation	...	...	...	...	...	...	...	9	1
Left school	...	...	...	...	...	...	...	6	—
Left district	...	...	...	...	...	...	...	1	1
Other reasons	...	...	...	...	...	...	...	—	—

G. Other Treatment Given:

				Number of cases known to have been dealt with	
				1962	1961
(a)	Pupils with minor ailments	...	...	318	358
(b)	Pupils who received convalescent treatment under School Health Service arrangements	...	...	5	15
(c)	Pupils who received B.C.G. vaccination	...	...	232	453
(d)	Other than a, b and c above—Ultra Violet Light	...	...	33	53
Total				588	879

Of the 33 school children who received ultra violet light treatment at the School Clinic 15 were still under treatment at the end of the year. Through the interavailability of clinics 6 pre-school children received ultra violet light treatment and of these 2 were still under treatment at the end of the year. Altogether 90 sessions were held at the School Clinic and 657 attendances made.

Handicapped Pupils:

Details of the number of handicapped pupils are given in the following table:—

TABLE V

	At a Special School	At an Ordinary School	Receiving Home Tuition	Not receiving suitable education
Blind Pupils	1	—	—	—
Partially Sighted Pupils	2	—	—	—
Deaf Pupils	7	—	—	—
Partially Deaf Pupils	3	8	—	—
Educationally Sub-normal Pupils	91	—	—	—
Epileptic Pupils	—	—	—	—
Maladjusted Pupils	7	3	—	—
Physically Handicapped Pupils	4	2	4	—
Pupils suffering from Speech Defect	—	—	—	—
Delicate Pupils	1	—	1	—
Total	116	13	5	—

Braithwaite Day Special School:

Ninety-one children were attending the Braithwaite Day Special School at the end of the year as against 75 for the previous year. Sixteen extra district children are now attending this school, the remainder being referred from schools situate in Keighley. There is a waiting list for admission to this school.

The school is satisfying a much felt need and the teachers there are undoubtedly doing valuable work in ensuring that these handicapped children are given as much education as possible to fit them for their future life in the world.

In addition 14 children were examined and found to have I.Q.s between 75 and 85 and were recommended to have special education in the ordinary school. It is hoped that by this means further deterioration in their performances will be avoided. Arrangements have, of course, been made for these children to be kept under constant review.

Nocturnal Enuresis:

During the year several children suffering from nocturnal enuresis were provided with an Eastleigh Electric Warning Device on loan. Seven children in all, six boys and one girl, were treated; five continuing under treatment at the end of the year.

Mentally Subnormal Children:

Three children were reported as being “unsuitable for education in school” under the provisions of Section 57(4) of the Education Act, 1944, as amended, and twelve children as requiring “care and guidance”.

Nutrition:

Arrangements were continued for the issue of branded foods free of charge to appropriate cases. The distribution of such foods is made on the authorisation of the School Medical Officer who examines each case prior to an issue being approved. The following foods were distributed during the year:—

	1962	1961
Ferromyn Tablets	70	112
Halibut Liver Oil Capsules	140	112
Maltoline—8oz. tins ...	—	8
Minadex—4oz. bottles ...	115	75
Vitamin B Tablets	48	—

Medical Examination of Entrants to Training Colleges:

Fifty-four students were medically examined in connection with their applications for entry to Training Colleges as compared with twenty-five in the previous year.

Children and Young Persons Act, 1933, Employment of Children:

Eighty-six children were examined by School Medical Officers to determine their fitness for employment under the Authority’s bye-laws relating to the employment of children as compared with 121 in 1961. The above figures include those children taking part in entertainments. Two children were found to be unfit.

Protection of School Children against Tuberculosis:

TUBERCULIN TESTING OF SCHOOL ENTRANTS:

Tuberculin testing of school entrants was introduced in order that in the case of a positive result it would lead to a search for a source of infection and at the same time secure the placing of the child under medical supervision in order to avoid the risks which follow primary infection.

The following shows details of the work undertaken under the provisions of this scheme:—

No. Invited	Refused	Absent	Previously Examined	Negative	Positive
890	94	142	6	646	2

Of the two cases found to be positive one had been previously vaccinated with B.C.G. and the other was referred for X-ray examination.

B.C.G. VACCINATION OF OLDER SCHOOL CHILDREN:

The scheme for the vaccination against tuberculosis of older school children continued during the year, details of which are set out below:—

Number of Medical Officers approved to undertake B.C.G. Vaccination	3
Acceptances—	
Number of children offered tuberculin testing and vaccination if necessary, whether the offer was made during the year or previously	871
Number found to have been vaccinated previously	1
Number of acceptances	293
Percentage of acceptances	33.7
Pre-vaccination Tuberculin Test—	
Number of children tested	286
Result of Heaf Test:	
(i) Positive 52; (ii) Negative 232; (iii) Not ascertained 2	286
Percentage positive	18.3
Vaccination—	
Number vaccinated	232

Dental Inspection and Treatment:

The arrangement as regards the dental inspection of pupils is that as far as possible:—

- (a) Every pupil who is admitted for the first time to a maintained school shall be inspected by a dental officer as soon as possible after the date of admission, and
- (b) Every pupil attending a maintained school or County College shall be inspected by a dental officer on such later occasions as may be practicable and necessary.

Details of the inspections and treatment carried out in connection with this service are given in the following table.

TABLE VI

	1962	1961
Number of pupils inspected—		
At periodic inspections	844	1,154
As specials	1,442	1,450
Total	2,286	2,604
Number found to require treatment	1,998	2,063
Number offered treatment	1,990	2,044
Number actually treated	1,850	1,867
Number of attendances	4,763	5,093

						1962	1961	
Half-days devoted to: Periodic (School) Inspection ...	...					7	7
					Treatment	...	468	490
					Total	...	475	497
Fillings: Permanent teeth	...	...	...	...	...	3,347	3,652
Temporary teeth	...	...	...	...	...	81	46
					Total	...	3,428	3,698
Number of teeth filled: Permanent teeth	...	...	...	...	...	3,280	3,550
Temporary teeth	...	...	...	...	...	74	42
					Total	...	3,354	3,592
Extractions: Permanent teeth	...	...	...	...	...	957	957
Temporary teeth	...	...	...	...	...	1,569	1,446
					Total	...	2,526	2,403
Administration of general anæsthetics for extraction	...					529	376	
Orthodontics—								
Cases commenced during the year	...	...	...	...	...	20	25
Cases carried forward from previous year	...	...	...	...	...	45	70
Cases completed during the year	...	...	...	...	...	20	30
Cases discontinued during the year	...	...	...	...	...	3	22
Pupils treated with appliances	...	...	...	...	...	65	95
Removable appliances fitted	...	...	...	...	...	54	56
Fixed appliances fitted	...	...	...	...	...	—	27
Total attendances	...	...	...	...	...	368	567
Number of pupils supplied with artificial dentures	...	...	...	...	...	39	65
Other operations: Permanent teeth	...	...	...	...	...	1,385	1,625
Temporary teeth	...	...	...	...	...	293	274
					Total	...	1,680	1,899

V. P. McDONAGH
Borough School Medical Officer

SUMMARY

In comparing the position in the School Health Service at the close of the year with that which obtained at the end of 1961, it will be seen that certain matters mentioned then have been remedied or improved, whilst others must be kept in mind as essential to the development of a full and comprehensive service. Briefly, the position can be summarised as follows:—

Residential Accommodation for Maladjusted Children

There is still an urgent need for more residential accommodation for maladjusted children. This is particularly acute with regard to accommodation for girls, for the County has had no provision for maladjusted girls since Hooper House was closed five years ago.

Psychiatric In-patient Units for Disturbed Children

There is an acute need for more psychiatric in-patient units for seriously disturbed children. The provision of these units is the responsibility of the Regional Hospital Boards and it is hoped that the plans of the Leeds Board to provide such a unit will materialise in the near future.

Child Guidance Service

The action envisaged in the previous report, i.e., seconding specially trained members of the County Medical Staff to this particular service, has been fulfilled. The outlook is now promising and the ultimate outcome promises a better and more efficient all-round service.

Audiology and Audiometry

Progress has been maintained and two Audiology Clinics are now operating on a satisfactory basis.

The number of pure-tone audiometers has been increased and will be further increased during 1963.

All children at special risk continue to receive audiometry tests and a routine test has been introduced for children in the 6–7 year age group.

Medical Examination of School Children

Results of the non-routine medical examination of school children have proved the merit of this scheme. It is now well established in certain areas and will be extended as desired.

Medical Staffing

It has been possible to make good all staffing losses. Many of the newly recruited medical officers, however, have very little Public Health experience and the increasing complexity of the School Health Service demands that all medical officers must keep abreast of modern techniques and knowledge. For this purpose, there must be a more liberal attendance at approved courses.

Food and Sweets in Schools

The tuck shop problem will continue to receive close attention.

QUESTIONNAIRE USED IN MEDICAL INSPECTIONS

(See page 196)

HEALTH SUMMARY

Child's full name.....

Date of birth..... Name of Family Dr.....

School attended.....

Any information given below will be regarded as strictly CONFIDENTIAL and will be seen only by the School Doctor and his staff.

1. How many attacks of tonsillitis has (s)he had in the past twelve months ?

.....

2. Has (s)he suffered from a running ear in the last twelve months ? (answer yes or no)

.....

3. Have you any reason to suspect deafness in your child ?

.....

4. Has (s)he had any serious chest trouble ?.....If so has (s)he attended hospital or chest clinic because of this ? (answer yes or no)

.....

5. Underline any of the following complaints if your child now suffers from them:—

Bed-wetting

Backwardness

Difficulty with speech

6. Has the child had any illnesses (including accidents) when (s)he has had to stay in hospital ? (answer yes or no)

.....

Nature of Illness or Injury

Age

Length of time in Hospital

.....

.....

.....

7. Is (s)he at present under treatment for any condition ? (answer yes or no)

.....

If " yes ", please state its nature.....

8. Have you any special worries about your child ?

.....

.....

.....

Signed.....(Parent or Guardian)

.....

.....

.....(Address)

.....(Date)